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ABSTRACT

A training program to promote links between the developmental disabilities system and historically black colleges and universities (HBCUs) is described. Objectives were to promote service delivery and the professional development of minorities in the developmental disabilities field. Three regional workshops in Alabama, Texas, and Virginia were attended by faculty from more than half of the nation's HBCUs (covering 16 states). The mini-team training model was developed and used by faculty. In addition to 15 hours of intensive preservice interdisciplinary training, faculty participants were provided with a training and resource guide for curriculum improvement. Curriculum enhancement strategies covered in the training included the following: change in course content/emphasis, development of new courses, interdisciplinary course teaching, field trips to developmental disabilities service sites, field placement and internships, and guest lectures. In addition, participants were acquainted with some institutional cooperative mechanisms to enable HBCUs to develop course content and training programs in the field of developmental disabilities. In addition to presenting keynote addresses of the three workshops and information on the proceedings, workshop evaluations and outcomes are examined, and recommendations are offered. (SW)

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FINAL REPORT: A MODEL FOR INCREASED AND IMPROVED RELATIONSHIPS BETWEEN THE DEVELOPMENTAL DISABILITIES SYSTEM AND HISTORICALLY BLACK COLLEGES AND UNIVERSITIES

This is the final report of a project of national significance funded under Grant #90DD0013/01 by the Administration on Developmental Disabilities, Office of Human Development Services, U. S. Department of Health and Human Services. The report does not, however, reflect the policies or opinions of the Department of Health and Human Services.

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3

FOREWORD

The Alabama Center for Higher Education (ACHE) is a voluntary, academic consortium established in 1967 for the purpose of promoting interinstitutional cooperation among its members. Membership includes the seven, four year historically black colleges and universities in the state: Alabama A&M University, Normal; Alabama State University, Montgomery; Miles College, Birmingham; Oakwood College, Huntsville; Stillman College, Tuscaloosa; Talladega College, Talladega; and Tuskegee Institute, Tuskegee Institute.

The consortium is governed by its Board of Directors made up of the Presidents of the seven member colleges and universities. An Advisory Board of Deputies, appointed by the Board, works closely with the Executive Director in program planning and development. This Advisory board, made up of the Chief Academic Officers, appoints and chairs program committees which include faculty representatives from each of the member institutions. It is at this level that cooperative programs are planned and developed. A small consortium staff assists with program planning and implementation.

Over the past 14 years, the member institutions have cooperatively developed and implemented more than two dozen programs which cover a broad spectrum such as dual degree programs, faculty development, student services, resource development and cooperative curriculum development programs such as the project described in this report.

This final report is the result of work performed under Grant #90DD013/01 awarded by the Administration on Developmental Disabilities, Office of Human Development Services, U.S. Department of Health and Human Services.

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This project of national significance was made possible by a grant from the Administration on Developmental Disabilities, Office of Human Development Services, United States Department of Health and Human Services. We at Alabama Center for Higher Education (ACHE) give special thanks and appreciation to our Program Officer, Mrs. Thelma Lucas, for her guidance and constant support, and to Dr. Jean K. Elder, U. S. Commissioner of Developmental Disabilities, for her cooperation and assistance.

Significant to this national model on collaboration between the historically black colleges and universities and the developmental disabilities system are a number of linkages with cooperating agencies, institutions, and organizations without whose support the project could not have been successfully implemented. To the named and un-named persons representing this network, we express our appreciation and gratitude.

- Southern Regional Education Board
  - Commission on Mental Health and Human Services
    Dr. Harold L. McPheeters, Director
  - Mental Health Manpower Development in the South
    Dr. Paul M. McCullough, Project Director

- Alabama State Department of Mental Health
  Mr. Glenn Ireland, Commissioner
  - Office of Human Resources Development
    formerly Office of Planning and Staff Development
    Mr. Arthur Patton, Director
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    Dr. Ross Hart, Assistant Director
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  - Division of Mental Retardation
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  - Alabama Developmental Disabilities Planning Council
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- Office of Personnel Services
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- Brewer Developmental Center
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- Texas Department of Mental Health and Mental Retardation
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- Department of Mental Health and Mental Retardation, Commonwealth of Virginia
  Dr. Joseph Bevilacqua, Commissioner
  Dr. Raymond F. Holmes, Assistant Commissioner, Mental Retardation
  - Southside Virginia Training Center
    Dr. Richard E. Buckley, Director
    Mr. Agenor L. Castro, Assistant Director, Community Affairs

- University Affiliated Facilities
  - Ohio University Affiliated Center for Human Development, Athens, Ohio
    Dr. Hilda Richards, Dean, College of Health and Human Services
  - Chauncey C. Sparks Center for Developmental and Learning Disorders, University of Alabama in Birmingham
    Dr. Wes Libb, Associate Director

Special thanks are owed the staffs of Brewer Developmental Center, Austin State School, and Southside Virginia Training Center who assisted with the logistics for the regional workshops. The administrations of the 38 HBCU's are thanked for the participation of their faculty members in the regional workshops, as are the faculty trainees themselves, without whose participation the workshops would have been futile. To the three persons who so effectively addressed national issues and concerns through their opening keynote speeches, we are especially appreciative of your participation and cooperation: Mrs. Yetta W. Galiber, Executive Director of the Information Center for Handicapped Individuals in Washington, D. C.; Dr. Raymond F. Holmes, Assistant Commissioner for for Mental Retardation, Virginia Department of Mental Health and Mental Retardation; and Dr. Walter Barwick, Deputy Director, White House Initiative on Black Colleges and Universities, U. S. Department of Education.

The Mini-Training Team, made up of faculty from the consortium's member institutions who are involved in disciplines/professions related to developmental disabilities, is given special recognition and thanked for their support in the planning and conduct of the regional and statewide workshops, preparation of the training manual, and the preparation of this final report: Alabama A&M University - Dr. James Hicks, Mrs. Ann Warren, and Mrs. Ethel Saunders; Alabama State University - Drs. Theodore F. Childs (Team Chairman, formerly at Tuskegee Institute) and Hoyt Taylor; Oakwood College - Dr. Melvin Davis and Mrs. Aline Dormer; Talladega College - Dr. John Parrish; Tuskegee Institute - Dr. Francis A. Taylor, Mrs. Marie L. Moore, and Mrs. Naomi Hunt. Dr. William Lawson from Alabama State University is especially thanked for his continuing assistance and support as chairman of the project's evaluation team which was made up of members of the Mini-Training Team.

Finally, we express special thanks to the consortium's staff who so ably assisted the project's staff with program activities and development of this report with special recognition given to Colette Monroe, Lula Lynn, Brenda McNeil, Esther Macon and Rosalind Buckingham.

7

TABLE OF CONTENTS

PAGE

FOREWORD iii

ACKNOWLEDGEMENTS iv

LIST OF TABLES ix

SECTION I. INTRODUCTION 1

- Needs and Resources 2
- Methodology and Project Design 6

SECTION II. WORKSHOP PROCEEDINGS 18

- Overview of Workshops 18
- Expected Outcomes 19
- Workshop Schedule 20
- Keynote Address for the Alabama Workshop 25
- Keynote Address for the Texas Workshop 34
- Keynote Address for the Virginia Workshop 42
- Analysis: Pre-Test and Post-Tests 47
- Training Manual 57
- Workshop Participants 58

SECTION III. WORKSHOP EVALUATION 59

- Alabama Workshop 59
- Texas Workshop 60
- Virginia Workshop 61

SECTION IV. WORKSHOP OUTCOMES 63

- Procedure for Developing Institutional Plans 63
- Curriculum Enhancement Plans 63
- Interinstitutional Cooperation 71

SECTION V. SUMMARY 80

SECTION VI. RECOMMENDATIONS 83

APPENDIX A. Resources Developed by the Project 86

B. Workshop Schedules 88
Alabama Regional Workshop 89
Texas Regional Workshop 93
Virginia Regional Workshop 97
Alabama DD Workshop 101

C. Workshop Participants 105

D. Participant Evaluation Form 114

E. Curriculum Development Planning Form 117

LIST OF TABLES

Page

Table 1: Location of Historically Black Colleges and Universities (HBCU's) Within SREB Coverage Area 12

Table 2: SREB States by Standard Federal Region 13

Table 3: Workshop Schedule by States 14

Table 4: Distribution of Scores for Pre-Test and Post-Test: Alabama Workshop 49

Table 5: Distribution of Scores for Pre-Test and Post-Test: Texas Workshop 51

Table 6: Distribution of Scores for Pre-Test and Post-Test: Virginia Workshop 53

Table 7: Distribution of Scores for Pre-Test and Post-Test: Combined Workshops 55

Table 8: Faculty Participants by State and Workshop 58

INTRODUCTION

The Alabama Center for Higher Education (ACHE) is a voluntary, academic consortium established in 1967 for the purpose of promoting interinstitutional cooperation among its members. Membership includes the seven, four year, historically black colleges and universities in the state: Alabama A&M University, Normal; Alabama State University, Montgomery; Miles College, Birmingham; Oakwood College, Huntsville; Stillman College, Tuscaloosa; Talladega College, Talladega; and Tuskegee Institute, Tuskegee Institute.

One programmatic thrust of the consortium focuses on the development of cooperative strategies for the purpose of increasing the number of minority professionals in the State's Mental Health System. Recognizing the implications for replicability and a need to disseminate widely information relative to the model project, ACHE was awarded a grant by the Department of Health and Human Services' Administration on Developmental Disabilities to:

> Implement strategies for the purpose of increasing the number and quality of minority professionals in the developmental disabilities service system; and
>
> Develop a model for increased and improved relationships with the developmental disabilities service system which may be replicated by historically black colleges and universities both individually and collectively.

Three regional workshops were convened at residential facilities for the developmentally disabled for faculty from HBCU's across the country who represent disciplines that have the knowledge/skills basic to solving problems unique to persons with developmental disabilities to include:

Psychology
Occupational Therapy
Nursing
Recreation Therapy
Physical Therapy
Nutrition/Dietetics
Social Work
Special Education

Workshop dates and sites follow . . .

Workshop I - March 31 - April 2, 1982
Brewer Developmental Center - Quality Inn
Mobile, Alabama

Workshop II - April 14 - 16, 1982
Austin State School - Villa Capri Motor Hotel
Austin, Texas

Workshop III - April 21 - 23, 1982
Southside Virginia Training Center - Ramada Inn
Petersburg, Virginia

Through these workshops, the development of a Training Manual made available to all faculty participants as well as published Workshop Proceedings and other follow-up strategies, ACHE assumed a lead role in bridging the gap between historically black colleges and universities and the developmental disabilities system by providing the framework for this national model through collaboration.

Needs and Resources

Client Population

In a 1979 published study, The Developmental Disabilities Movement: A National Study of Minority Participation (New Dimensions in Community Service, 1979), the number of persons with developmental disabilities was approximately 8,500,000. Of this number, only 18% are estimated as receiving services from various agencies providing programs (1,546,000). An estimated 324,660 persons served are persons from minority populations. This study also reviews the literature, which reveals that there is a high correlation showing the greater the number of minorities in decision-making positions, the more minority consumers utilize the system.

Manpower

Manpower needs are reflected by existing positions that are unfilled in the developmental disabilities system. Needs for manpower are also reflected in the surveys of unmet needs, identified by selected populations. According to PL 94-103 and 95-602, areas of staff involvement are in administration, direct service, outreach, clerical and volunteerism. These positions may be in such service categories as client identification, direct service, treatment, education, residential services, employment, and family/program support.

Client needs which reflect occupational options in the developmental disabilities service delivery system include, but are not limited to, the following:

1. Public administration, hospital management, executive directors.
2. Social service, social work, legal services, counseling, psychology.
3. Medical, dental, health-related treatment service (Occupational Therapy, Physical Therapy, Speech Therapy, Creative Arts Therapy), nursing, nutrition.
4. Pre-school/early childhood education, special education, adult education, day-care professional programs.
5. Domiciliary care administrator, special living arrangements coordinator.
6. Vocational counseling, job placement specialist, work adjustment/training, vocational evaluation.
7. Recreation specialist.

Those persons planning to enter professions or careers that serve persons with developmental disabilities need to identify agencies and facilities within the public-supported system and the voluntary health system. This may be done through periodic contact with the state employment service, college placement office, and the National Health Careers Program. The national voluntary health and professional organizations also provide career information.

There remains a paucity of black professionals in the developmental disabilities system. Whereby blacks are highly represented in positions requiring on-the-job training (i.e., aides, technicians, and support personnel), professionals in direct service, middle management and top management are less than three percent. Black college students exploring undergraduate and graduate programs need to look at criteria for entry level into specific professional fields. Criteria may include type of degree and certification or licensure. Some careers require an academic background in social service, behavioral science, business or education in which knowledge/skill may be applied to the developmentally disabled population.

High school and college career counselors need to be cognizant of the career fields that will offer minority students golden opportunities in health and human services. College curricula should include survey courses that focus on careers in developmental disabilities.

Roles of Professionals in the Developmental Disabilities System

The public-supported programs are the result of federal and state mandates. The professional may serve one of three roles in the public-supported system:

1. Direct service provider
2. Administrator in the state system, or
3. The volunteer board member of the State Developmental Disabilities Council or Protection and Advocacy System.

The latter two categories deal with policymaking and the implementation of policy.

The volunteer-supported system for the developmentally disabled was initially established to meet unmet needs. The professional may serve one of two roles: direct service as a staff person, and/or volunteer board or committee membership. Volunteer organizations are maintained primarily by the affluent members of our society. Thus, members of minority groups have difficulty in entering the volunteer structure, since this structure is developed around social relationships. Also, priorities within the black communities and communities of other ethnic minorities are different than the affluent majority. Volunteer organizations have developed outreach strategies that have recruited a token number of blacks into the system. They have also attempted to develop coalitions with predominantly black and other ethnic minority organizations.

The black professional in the developmental disabilities system, both public and private, has two major roles: direct service provider, and change agent. Both roles are related to problems faced by minority consumers/potential consumers of the developmental disabilities system.

The role of the direct service provider is determined by job description and professional expertise. The minority direct service provider also has unique linkage with the minority client and his/her community. This linkage allows the professional to assist the client in the necessary negotiations within the developmental disabilities system, as well as providing specific services associated with the professional discipline.

The role of the change agent or advocate for the professional may be associated with his/her job or participation as a volunteer. If the professional who is black finds herself/himself a token in numbers, this is the first phase of being a change agent; the next is identification and recruitment of other minority persons who are able to make valuable contributions in the decision-making arenas. Recruitment of others should use the criteria of life experience as well as academic/professional experience.

Removal of barriers within the developmental disabilities system and filling gaps of service delivery are the issues that are addressed by the change agent. Addressing the needs of persons who are unserved, underserved, or mis-served must be a focus of the change agent. There are a number of issues unresolved that are related to persons with developmental disabilities. These issues include, but are not limited to, the following:

1. Increased early teenage pregnancy with a higher incidence of babies born with developmental problems.
2. Child abuse and child neglect resulting in developmental problems.
3. Persons with developmental disabilities in the criminal justice system.
4. Health-care problems as a low priority among low income families.

Methodology and Project Design

In developing this project of national significance, the Administration on Developmental Disabilities established the major purposes and primary objectives which follow.

Purposes: To have a direct impact on developmental disabilities programs throughout the country;

To have an objective which if achieved could be replicated, could result in an improved delivery system for developmental disabilities services, or could affect national policies and/or standards; and

To involve activities to be conducted in a number of sites in various parts of the country as a part of a unified program.

Objectives: Secure programmatic and other information including replicable course outline materials relative to the provision of services to persons with developmental disabilities from the University Affiliated Facilities (UAF's);

Establish cooperative agreements with UAF's and/or other local community-based or residential providers of services in order to provide practicum on-site experiences for students.

Provide counseling and disseminate programmatic information pertaining to techniques and skills related to the provision of services to persons with developmental disabilities; generally integrate these materials into career development activities; and

Conduct three regional training sessions in areas where there is a heavy concentration of black colleges and universities.

ACHE's development of this model was dependent on an existing network with the Alabama State Department of Mental Health; the Southern Regional Education Board's Commission on Mental Health and Human Services, Mental Health Manpower Development in the South project, and Institute on Higher Educational Opportunity; the National Citizen's Participation Council (on DD); and two University Affiliated Facilities: Chauncey C. Sparks Center for Developmental and Learning Disorders at the University of Alabama in Birmingham and Ohio University's Affiliated

Center for Human Development. With this collaborative network in place, ACHE was in a unique position for its member colleges and universities to assume the lead role in bridging the gap between the DD system and black colleges and universities nationally.

Hence, the project's enabling objective was twofold:

- To implement strategies for the purpose of increasing the quality and number of minority professionals in the developmental disabilities system; and
- To develop a model for increased and improved relationships with the developmental disabilities system which may be replicated by historically black colleges and universities both individually and collectively.

Activities to accomplish this enabling objective focused on the mini-team concept.

Mini-Team Concept

The problem of persons with a developmental disability may be so complex that family members and helping professionals have been restricted in their efforts to provide comprehensive programs, services and developmental care. In the late 1960's, representatives from the National Association for Retarded Citizens, United Cerebral Palsy Association, Inc., the University of Indiana, University of Wisconsin and Central Wisconsin Colony and Training School (now Developmental Center) met to pool their knowledge relative to the care, treatment and program planning requirements for persons with severe profound, multiple disabling conditions. Out of this series of meetings, the concept of "cross disciplinary" and "cross modality" training of professionals evolved. As the result, small teams of persons from six institutions were trained in new approaches to therapeutic care of institutional residents. The "mini-team" was born.

In the mid 1970's, the mini-team concept was broadened to include a number of professional disciplines. Whereas the original mini-teams included only the professions of Nursing, Physical Therapy and Occupational Therapy -- the new mini-teams included combinations of professionals from other disciplines such as Speech Pathology, Therapeutic Recreation, Special Education, Social Work and Nutrition. United Cerebral Palsy of New York State initiated the use of the mini-team for training of direct-care personnel in a state institution by consultant mini-teams from the private sector.

The original mini-team consists of persons willing and able to work with others in the development of jointly planned programs for one or more persons with developmental disabilities. These team members assume responsibility for providing cooperative and coordinated services/treatment using knowledge/skill from the participating professional disciplines. Problem solving and intervention are based on interdisciplinary efforts of the team. With the most sophisticated teams, a transdisciplinary approach has evolved -- whereby team members are committed to teaching/learning/working together with others across traditional disciplinary boundaries.

The transdisciplinary approach is the deliberate pooling/exchange of knowledge and skills which result in continuous crossing of traditional disciplinary boundaries within the limits of licensure by team members. Thus the teaching/learning activities of the team are focused around the needs and problems of persons with developmental disabilities. Once trained to operate in the transdisciplinary approach, any one team can work as the primary case coordinator in the habilitation process for the client with DD. This includes training others in therapeutic management and developmental programming. Other team members are utilized as consultants in the case management developmental program.

The success of the interdisciplinary team as teacher, consultant, program service provider is well documented in terms of cost effectiveness and impact on the development of persons with severe/profound limitations. This is the case for both residential/institutional based programs and community services.

Several processes have been constant in the development of the mini-team as trainers and as service providers:

1) The team members learn from each other in an environment where persons with developmental disabilities receive services.

2) Team members teach others in an environment where the person with a developmental disability is provided services.

3) Team members are competent as generalists in the knowledge/skill of their own discipline prior to becoming a team member who is able to cross disciplinary lines.

4) Team members teach in an interaction process with other team members, the trainees, the persons with the developmental disability and their families.

The mini-team is capable of covering curriculum content in a number of areas that have great impact in the provision of services for persons with developmental disabilities:

1) Intervention strategies and techniques that promote normal growth and development when debilitating conditions are minimized.

2) Promotion of independent function in mobility, communication, self-maintenance, productivity and enrichment and leisure time pursuit.

3) Utilization of community resources in an advocacy approach relative to rights and entitlements of each person with a developmental disability.

Mini-team members are selected from those professional disciplines that have knowledge/skill basic to solving problems that are innate/unique for persons with developmental disabilities. Areas of expertise include neuromotor facilitation, sensory integration facilitation, skills development in mobility, communication and self-maintenance, role behavior development, cognitive development, and utilization of community resources.

Mini-Team Trainers

The use of a Developmental Disabilities Mini-Training Team was considered an effective method of orientating and demonstrating how a group of different professional disciplines can utilize their skills in concert. This approach is effective because developmental disabilities represent a consolidation of functional dysfunctions that requires the expertise and training of several disciplines. A team of experienced trainers can transmit their skills to others less skilled, and also orientate nonprofessionals to the nature and needs of the developmentally disabled in a realistic manner. No other method is more effective than actual demonstration in a relevant setting. This methodology will be subsequently employed to motivate undergraduate students from historically black colleges and universities to careers in the demonstrated health disciplines.

The demonstration team was drawn from the faculty of the ACHE member institutions and made up of Black professionals who have had experience with the developmentally disabled. One person from each of the following disciplines was a part of the demonstration team: Psychology, Physical Therapy, Occupational Therapy, Dietetics, Nursing, Social Work, Recreation Therapy, Special Education and Mobility and Sensory Training.

Training Sites

Geographic locations of the historically black colleges and universities and ACHE's collaborative relationship with the Southern Regional Education Board (SREB) were the predominant factors in determining the three states to be used as training sites. As Tables 1 and 2 indicate, the SREB coverage area encompasses 14 states in which more than 90% (93 of 101) of the historically black colleges and universities are located and includes either in total or in part three of the ten standard federal regions.

Table 1

Location of Historically Black Colleges and Universities (HBCU's)

Within SREB Coverage Area

State	Number of HBCU's	Number of 4 year HBCU's
Maryland	4	4
Virginia	6	5
West Virginia	0	0
Alabama	12	7
Florida	4	4
Georgia	10	10
Kentucky	1	1
Mississippi	11	6
North Carolina	11	11
South Carolina	8	6
Tennessee	7	6
Arkansas	4	3
Louisiana	6	5
Texas	9	8
Totals	93	76

Taken from the Second Annual Report - 1978 of the National Advisory Committee on Black Higher Education and Black Colleges and Universities.

Table 2

SREB States By Standard Federal Region

Federal Region	SREB States
Three (six states)	Maryland, Virginia, West Virginia (three of the six states)
Four (eight states)	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee (all of the eight states)
Six (five states)	Arkansas, Louisiana, Texas (three of the five states)

Within each of the three standard federal regions, states were selected which had a heavy concentration of HBCU's and widely recognized, large residential institutions for the developmentally disabled. With Alabama in Region IV and the home base for the project, it was naturally selected as the workshop site. Texas was selected from Region VI as was Virginia from Region III.

The actual sites within the states were selected for a number of reasons which follow.

1. The team required a large pool of residents who were representative of the variety of dysfunctions presented by the developmentally disabled.
2. The trainees in the program needed to be sensitized to a large target population to insure a conceptualization of the nature and needs of the developmentally disabled.
3. Since the state of the art implies deinstitutionalization, it was crucial that the nature of the institution be made vivid.
4. The trainees could benefit from an administrative overview of the special concerns and considerations that are required if the problems of the developmentally disabled are to be grasped.

Specific sites within states were: Alabama - Brewer Developmental Center, Mobile; Texas - Austin State School, Austin; and Virginia - Southside Training Center, Petersburg.

Selection of Trainees

Trainees were faculty from HBCU's who represented disciplines and professions that have the knowledge/skills basic to solving problems unique to persons with developmental disabilities, these were

- Psychology
- Occupational Therapy
- Physical Therapy
- Social Work
- Nursing
- Recreation Therapy
- Nutrition/Dietetics
- Special Education

For logistical purposes, attendance at workshops was not based on the boundaries imposed by the federal regions but on geographic proximity to the site and number of HBCU's that could realistically be involved in a specified workshop. Via informational leaflets and packets of information forwarded to Presidents and Vice Presidents/ Deans of Academic Affairs, faculty representing the noted areas were invited to participate in a specified workshop as reflected in Table 3.

Table 3

Workshop Schedule By States

Workshop	State	No. 4 year HBCU's	
ALABAMA	Alabama	7	
	Florida	4	
	Georgia	8	
	Tennessee	6	
			(25)
TEXAS	Arkansas	3	
	Louisiana	5	
	Mississippi	5	
	Oklahoma	1	
	Texas	8	
			(22)

Table 3 (continued)

Workshop Schedule By States

Workshop	State	No. 4 year HBCU's
VIRGINIA	Kentucky	1
	North Carolina	10
	Pennsylvania	2
	South Carolina	6
	Virginia	4
	Ohio	2
	Delaware	1
	Maryland	4
	Washington, D. C.	1
		(31)

Training

It was proposed that trainees would be provided 15 hours of intensive pre-service interdisciplinary training based on a training model developed by a University Affiliated Facility - Ohio University's Affiliated Center for Human Development in Athens. This model, modified by the consortium's faculty planning team, was designed for training service providers already licensed in their respective professional disciplines. The modification resulted in a model designed for training faculty members which follows.

• Pre-Testing and Orientation	1/2 hour
• Awareness	6 hours
• Mini-Team Training	3 hours
• Curriculum Enhancement Planning	4 hours
• Workshop Shareout	1 hour
• Post-Testing	1/2 hour

Pre-Testing and Orientation: Trainees were given the pre-test to determine the level of understanding and comprehension that they brought with them relative to the developmentally disabled. Though individual scores were not given, a group data base was formed.

Awareness: The videotape, "Davie Is Entitled," was shown to illustrate how the different professionals on a team work together. In working with Davie, a young developmentally disabled child, the team developed an Individualized Education Plan (IEP) for him. Significant was the intimate involvement of Davie's parents as an integral part of the team. "Davie Is Entitled" responded to the focal point of the workshops regarding how professionals work together as a team to have the greatest impact on the developmentally disabled client. The videotape was produced by the Center for Human Development at Ohio University, Dr. Elsie D. Hehsel, Director.

Keynote speeches opened the first full day of the workshops. Delivering the keynotes were persons representing various sectors of the DD system who provided a national awareness of key issues and concerns.

Via guided tours of the residential facilities where the workshops were held, trainees were provided an overview of the scope, nature and needs of the DD population. Included in the guided tours were housing areas, clinics, educational facilities, and recreation areas. Emphasis was placed on the special problems of minorities.

Mini-Team Training: Three concurrent workshops were conducted by the Mini-Training Teams comprised of faculty from five of the seven consortium member institutions. Each workshop covered the role, function, knowledge, and skills of the specified discipline/profession as they relate to professional practice in developmental disabilities settings, with a special focus on the following:

- the problem solving process;
- implications for curriculum development and training;
- the film - "Davie Is Entitled;" and
- the dialogue between the Mini-Training Team and participants.

All workshop participants attended each of the three sessions conducted by the Mini-Training Team, chaired by Dr. Theodore F. Childs, formerly Chairman of the Division of Allied Health and Professor of Health Science at Tuskegee Institute and presently Professor in the Department of Health, Physical Education and Recreation at Alabama State University.

Curriculum Enhancement Planning: Participants worked together by states to develop intra and interinstitutional plans which would lead to an increased focus on careers in the field of developmental disabilities by students enrolled at the respective institutions.

Workshop Shareout: Both the intra and interinstitutional work plans that were developed during the sessions on Curriculum Enhancement Planning were presented by spokespersons from each state. These combined workplans are presented in another section of the report. Significant among the plans was the strong commitment to expand and increase program offerings related to developmental disabilities.

Post-Testing: Trainees were given the post-test to determine the level of understanding and comprehension relative to the developmentally disabled upon completion of the 15 hours of training. A group data base was formed from the scores.

WORKSHOP PROCEEDINGS

Overview of Workshops

The use of a Developmental Disabilities Mini-Training Team was viewed as an effective method of orientating and demonstrating how a group of professionals from different disciplines can utilize their skills as a team. This approach is effective because developmental disabilities represent a consolidation of functional dysfunctions that require the expertise and training of several disciplines. A team of experienced trainers can transmit their skills to others less skilled and also orientate non-professionals to the nature and needs of the developmentally disabled in a realistic manner. No other method is more effective than actual demonstration in a relevant setting.

Hence, the Workshops were conducted by a Mini-Training Team comprised of one person from the following disciplines/professions: Psychology, Physical Therapy, Occupational Therapy, Dietetics, Nursing, Social Work, Recreation Therapy, Special Education and Mobility and Sensory Training.

The training sites were selected because each was a large residential institution for the developmentally disabled which provided a large pool of residents representative of the variety of dysfunctions presented by the developmentally disabled. Other reasons for the choice of sites were that: 1) workshop participants would be sensitized to a large target population to insure conceptualization of the nature and needs of the developmentally disabled; 2) the state of the art implies deinstitutionalization in the least restrictive environment, hence the nature of the institutions would be more vivid; and 3) participants would benefit from an administrative overview of the special concerns and considerations that is required if the problems of the developmentally disabled are to be grasped. Therefore, a major program focus included guided tours of the respective facilities.

The workshops provided 15 hours of intensive preservice interdisciplinary training based on a training model developed by the Ohio University Affiliated Center for Human Development in Athens.

Faculty participants from HBCU's across the country were expected to return to their campuses with the primary purpose of continuing the process of demonstrating and orientation. It was projected that this spin-off effect would maximize the effects of the workshops. A continuing process will be put into effect that will encourage increasing numbers of Black students to select developmental disabilities as a career option.

Training Manuals were provided each participant to be utilized both as a training guide and resource manual.

Expected Outcomes

These workshops on developmental disabilities were designed to:

1. Develop an understanding of the DD concept;
2. Develop an understanding of PL 94-103 as amended by PL 95-602;
3. Develop an awareness of those professions/disciplines contributing to the delivery of services within the DD system;
4. Develop an awareness of the training and preparation needs for practitioners in the DD service delivery system;
5. Develop an awareness of funding sources that may assist in the development of personnel preparation programs;

6. Develop an awareness of the current and future manpower needs within the DD service delivery system;
7. Develop an awarenesss of local, state, and federal agencies serving the developmentally disabled; and
8. Develop an awareness of the current status of minority professionals in DD service delivery systems.

Workshop Schedule

Session I

A workshop pre-test was conducted by Dr. William D. Lawson, Project Evaluator, to determine the extent of the participants' knowledge of developmental disabilities and the various disciplines which impart knowledge and develop skills relevant for working with the developmentally disabled. Results of the pre-test follow in a later section.

The videotape, "Davie Is Entitled" was shown to illustrate how the different professionals on a team work together. In working with Davie, a young developmentally disabled child, the team developed an Individualized Education Plan (IEP) for him. Significant is the intimate involvement of Davie's parents as an integral part of the team. "Davie Is Entitled" responds to the focal point of the workshops, how do professionals work together as a team to have the greatest impact on the developmentally disabled client. The video tape was produced by the Center for Human Development at Ohio University, Dr. Elsie D. Hehsel, Director.

Session II

For the Alabama Workshop, greetings were extended by Ms. Cathy Arnett, Assistant Director of Brewer Developmental Center and Mr. Henry E. Ervin, Manager-Office of Personnel Services, Alabama Department of

Mental Health. During the Texas Workshop, greetings were extended by Dr. B. R. Walker, Superintendent of Austin State School, The Honorable Wilhelmina Delco, State Representative, and Mr. Volma Overton, President - Austin NAACP. For the Virginia Workshop, greetings were extended by Dr. Raymond F. Holmes, Assistant Commissioner for Mental Retardation - Virginia Department of Mental Health/Mental Retardation, Mr. A. L. Castro, Assistant Director/Community Affairs and Mr. Jim Bumpas, Assistant Director/Administration, both from Southside Virginia Training Center.

Keynote speakers were introduced by the Project's Co-Director, Reynard R. McMillian; they were:

Alabama	Mrs. Yetta W. Galiber Executive Director, Information Center for Handicapped Individuals, Inc. Washington, D. C.
Texas	Dr. Raymond F. Holmes Assistant Commissioner for Mental Retardation Department of Mental Health and Mental Retardation Richmond, VA
Virginia	Dr. Walter Barwick Deputy Director, White House Initiative on Black Colleges and Universities U. S. Department of Education Washington, D. C.

Guided tours of each training site were conducted by staff at each of the facilities. These tours were designed to provide the reality base to the workshops in addition to: 1) sensitizing the participants to the DD client; 2) showing how the professionals react with the clients; and 3) increasing participant awareness of the overall administrative problems that beset an institution. Special note is made of the tour during the Virginia Workshop in that the participants were shown a film of where the institution was 10 years before. This provided some measure of the progress that had been made as a result of legislation and various court ordered mandates.

Albert P. Brewer Developmental Center, a 200 bed residential facility in Mobile, is one of five such centers in the state which serves a 15 county area in Southwest Alabama. Brewer is operated by the Alabama Department of Mental Health. Austin State School in Texas, an 800 bed facility, is one of 13 residential training facilities for mentally retarded persons in Texas, operated by the Texas Department of Mental Health and Mental Retardation. Southside Virginia Training Center provides training, therapeutic, and habilitative services for almost 900 residents. SVTC shares several services with Central State Hospital on whose grounds the majority of its buildings are located. Both are operated by the Department of Mental Health and Mental Retardation, Commonwealth of Virginia.

Session III

Three concurrent workshops were conducted by the Mini-Training Teams comprised of faculty from five of the seven consortium member institutions. Each workshop covered the role, function, knowledge, and skills of the specified discipline/professions as they relate to professional practice in developmental disabilities settings, with a special focus on the following:

- the problem solving process;
- implications for curriculum development and training;
- the film - "Davie Is Entitled;" and
- the dialogue between the Mini-Training Team and participants.

All workshop participants attended each of the three sessions conducted by the Mini-Training Team, chaired by Dr. Theodore F. Childs, Chairman of the Division of Allied Health and Professor of Health Science at Tuskegee Institute.

- Mini-Training Team I

  -Naomi Hunt, M.S. -- Physical Therapy
  Assistant Professor; Allied Health
  Department, Tuskegee Institute
  -James H. Hicks, Ed.D. -- Special Education
  Chairperson, Special Education Department,
  Alabama A&M University
  -Ann P. Warren, M.S. -- Nutrition
  Area Coordinator/Assistant Professor, Food
  and Nutrition, Alabama A&M University
  *-Ethel Saunders, M.S. -- Nutrition
  Instructor, Food and Nutrition
  Alabama A&M University

- Mini-Training Team II

  -Marie L. Moore, M.S., O.T.R. -- Occupational Therapy
  Assistant Professor/Program Director,
  Occupational Therapy, Tuskegee Institute
  -Hoyt Taylor, Ed.D. -- Recreation Therapy
  Associate Professor/Chairperson, Recreation
  and Physical Education, Alabama State University
  -Melvin Davis, Ph.D. -- Psychology
  Professor/Director of Institutional
  Research, Oakwood College

- Mini-Training Team III

  -Aline B. Dormer, M.S. -- Nursing
  Associate Professor, Nursing Department
  Oakwood College
  -John L. Parrish, Ed.D. -- Mobility and Sensory Training
  Chairman, Division of Education
  Talladega College
  -Francis Taylor, Ph.D. -- Social Work
  Associate Professor/Department Head
  Social Work Department, Tuskegee Institute

Session IV

Dr. Francis Taylor, Mini-Training Team member in Social Work, led this session which focused on participants developing intra and inter-institutional plans. Participants worked together by states to prepare tentative plans for presentation during Session V.

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*Ethel Saunders substituted for Ann Warren who was on maternity leave during the last two workshops.

Session V

Spokespersons from each state in attendance presented work plans that had been developed during Session IV which are presented in another section of this report. Faculty participants left each Workshop with a strong commitment to expand and increase program offerings related to developmental disabilities.

Dr. William Lawson, Project Evaluator, conducted the Workshop Post-Test, the results of which follow in a later section. Following the Post-Test, an anonymous evaluation of the workshop by participants was completed with results provided in a later section.

Keynote Address for the Alabama Workshop

presented by

Yetta W. Galiber
Executive Director
Information Center for Handicapped Individuals, Inc.
Washington, D. C.

Most of us can remember being led in song at an elementary school assembly by a teacher who came out and either blew a pitchpipe or hit a key on the piano to give us the starting tone. I feel somewhat like that teacher this morning hoping my keynote will be close to yours - not pitched too high or too low. Above all we must remember what has brought us together. We must be aware of the challenge, the need, the opportunity we have before us. We can make harmonious music, if we heed each other's voices - if we determine that we will be a part of the solution to the dissonance that plagues poor black developmentally disabled persons in this country.

It is estimated that 10% of the worlds population or 450 million people are mentally or physically disabled. Three quarters are receiving no trained help whatsoever. One hundred forty six million of the disabled are children under the age of 15. Of that number, six million are in North America. The incidence of disability is increased by malnutrition and disease in pregnancy and early childhood; but decreased by a lower life expectancy and higher rates of infant mortality. Malnutrition is the greatest single cause of disability which impairs both mind and body. Every year 250,000 children lose their eyesight through the lack of Vitamin A.

We, in the U. S. are faced with an additional dilemma of staggering seriousness. Our minority disabled citizens are suffering, are being ignored, are dying physically and spiritually - are hungry, unclothed, unemployed, unsheltered, and completely unaware of the better life which is their right.

In the last two decades, in an effort to express our growing concern for handicapped persons, our society has thrust itself deeply into the area of personal rehabilitation. This concern has been evidenced nowhere more strongly than in legislation, resulting in programs designed to help the handicapped population. Regulations to these laws clearly require outreach so that blacks and other minorities can share in these rights and have their ways of life respected and incorporated into institutional and social service programs. However, as a result of the historical climate with its ever-present racism, blacks and other minorities are over-represented in every statistical indicator of socio-economic and health ranks and remain at risk with continuous and periodic episodes of acute anxiety attacks, depression, and personality disorders in an attempt to survive.

Members of black and other minority disabled groups are isolated from the mainstream of the service delivery systems and experience great difficulty in locating and accessing services. Social service professionals who are predominantly of the majority race, traditionally show concern for the problems of blacks and other minority handicapped persons, but most often this concern has been patronizing and self fulfilling of the needs of the white establishment rather than of blacks and other minority groups. Over the past ten years the developmental disabilities movement has been a growing part of American life. Families with developmentally disabled members have been making increasing demands for more appropriate services. Negative attitudes toward the developmentally disabled have been changing and society is beginning to recognize that developmentally disabled persons have the right to acquire education, job skills, and to lead as normal a life as possible.

However, due to attitudinal, language, economic, geographical, and transportational barriers, blacks and other minority developmentally disabled individuals have been systematically excluded from obtaining the health and human services to which they are entitled. These groups have been further alienated from interaction with the service delivery system because of the influence of culture and sub culture-dynamics, more specifically, beliefs, biases, perceptions and values.

In addition to these physical, economic and psychological barriers, there is a lack of genetic counseling and testing and a lack of accessible housing available to minority developmentally disabled individuals. These obstacles create a reluctance among blacks, and other minorities to interact with the majority society. Blacks and other minority developmentally disabled individuals also lack the knowledge of their rights and protection under Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Blacks and other minorities are not aware of the protection and advocacy systems as mandated by P.L. 94-103. I am the only black director of a protection and advocacy system in this country and know for a fact that most protection and advocacy systems have a dearth of minority staff. Most protection and advocacy systems engage in little or no outreach efforts to minority developmentally disabled persons. It is also a fact that blacks and other minority developmentally disabled individuals are underserved or unserved by health and human service provider agencies throughout the country. As a matter of fact the health and human service provider agencies generally are also unfamiliar with the provisions of Title VI and Section 504 and are most often not in compliance with these laws.

There is a lack of bilingual personnel and a lack of data on the racial/ethnic backgrounds of the developmentally disabled clients served by provider agencies. Provider agencies do not institute outreach programs to encourage participation of blacks and other minority developmentally disabled consumers. And as you know, there exists a minimal number of black professionals trained in the area of developmental disabilities.

In 1980, the Minority Affairs Committee of the National Association of Protection and Advocacy Systems of which I am chairperson influenced the Office of Civil Rights and the Administration on Developmental Disabilities to fund seven protection and advocacy systems to provide outreach services to ethnic minority developmentally disabled persons as follows: California Protection and Advocacy - Asians; Arizona and New Mexico Protection and Advocacy - Native Americans; Texas Protection and Advocacy - Rural Mexican Americans; D.C. Protection and Advocacy - Urban Hispanics; West Virginia Protection and Advocacy - Rural Blacks, and Maryland Protection and Advocacy - Urban Blacks.

These projects have made significant gains in identifying and assisting ethnic minority developmentally disabled individuals in obtaining appropriate health and human services. Materials have been developed in native languages, training has been provided to service providers, parents and consumers on legal and social entitlements.

But now we face additional major budget reductions in areas that severely impact handicapped persons particularly blacks and other minorities. In February 1982, the Childrens Defense Fund sponsored a conference on the proposed budget cuts that will drastically reduce services for children. Let me share with you information regarding the present health of black children in this country which presents the dismal circumstances of poor black children resulting most often in serious developmental disabilities.

The National Black Child Development Institute in their 1980 report on the status of black children found that black children are much more likely to suffer from poor health than the majority of their American peers. While poverty, unsafe housing, and poor nutrition expose many black children to harmful and hazardous conditions, their plight is compounded by systematic inaccessibility to competent health care. Together, these factors help to make many black children a population substantially at risk with no resources for assistance.

The statistics detailing the effects of deteriorating environments are particularly grim. The National Center for Health Statistics found that black infants are almost twice as likely as white infants to die before their first birthday. A black child has a 30% greater probability of dying by his/her fourteenth birthday than does a white child. Black children are more than 30% as likely as white children to die from fatal accidents. Black children who live in poverty will need to miss an average of two more days a year from school due to acute illness than will higher-income children. Indeed, should a black child live in deteriorating housing, he/she will have a 25% chance of having excessively high levels of lead in his/her teeth and blood.

Given the greater susceptibility of poor children to serious health complications, then, the relative inaccessibility of many black children to competent medical care is as disturbing as it is disgraceful. Over 40% of all black children, compared to 29% of whites, do not see a single physician each year, and even worse, 17% of all black children have no regular place of care despite their strong possibility of poor health. If one considers that 30% of all black children use only institutional care, the dissimilarities become more explainable. Families without a regular physician cannot receive the constant care that is integral to effective preventive medicine. Black children, as a result, are much more likely not to receive basic immunizations against the most dangerous of childhood diseases. Less than half of all black children have received three polio dosages as recommended, and only 58% of black children have ever received an innoculation against measles. Understandably, then, black children are 25% more prone to measles infections than are their white counterparts.

No statistic captures better the hazard of being born black than does the exceptionally high incidence of infant mortality. Indeed, even though the 1976 black infant mortality rate of 25.5 deaths per 1,000 births continued a steady downward trend, white babies twenty-five years earlier had the same chance for survival. More than any other factor, the delay or the absence of prenatal care accounts for high incidences of infant mortality since early health problems can go undetected without prenatal care. Black women are twice as likely as whites to never have prenatal care. While for each month of pregnancy, black women again are twice as likely to have not obtained prenatal care. Should a mother go without effective prenatal care, she will then be three times as likely to bear an underweight baby susceptible to infant mortality, prematurity, mental retardation and malnutrition. That over 13% of all black babies are born with low birth weights is therefore a dramatic reminder of the poor health that plagues many black children from the cradle on through adulthood.

The high rate of pregnancies among young black women poses a further health hazard. Due to inadequate health information and accessibility, black adolescent mothers are the group most likely not to receive prenatal care or else to delay it until the last three months of pregnancy. As many as one-fifth of all births to black teenagers therefore result in low birth weights, a clear indication of the severe health complications of the crisis. It was an ironic tragedy that in 1981 the International Year of Disabled Persons, the present administration called for broad-based reductions of federal support for most of the primary service systems such as social security disability insurance, medicaid, medicare, vocational rehabilitation, developmental disability programs, mental health service and education for handicapped children. The reductions from prior budget estimates for these programs and other back up service delivery systems will be more than 55 billion dollars annually by 1986. The combined result of these proposed budget cuts on many disabled persons and their families will be devastating. Many disabled people who are now barely coping with the multiple strains on their lives will face new levels of psychosocial as well as family and financial difficulties. Significant numbers of disabled persons, especially black and other minorities will continue to "fall through the cracks." Health problems will increase as well as the frequency of hospitalization. More disabled persons will be unemployed and more will be forced into a welfare status. Greatly increased competition at the local and state level for much reduced program services will become a divisive factor in the social fabric of community life. Representatives of various vulnerable groups will be pitted against each other in a struggle to satisfy needs with more limited resources. The effect on the minority disabled, given their intense vulnerability, will likely result in much greater isolation and increased dependence.

In the present state of the nation, we are at a cross-roads in the field of developmental disabilities. The federal support that we have relied upon so heavily has now begun to literally dry up. In its place is a new federalism on non-involvement and restraint that I believe has strong overtones of racism. In the very near future, there will be even less money, less technical assistance, and less in the way of broad-based rights and due process protections that were previously untainted by the strains of competing economic interests and hidden state agendas.

The state of this economy demands creative solutions. The black universities have the unique opportunity and responsibility to respond to the challenges of this pilot project. The black universities in the country must assume the leadership and provide the direction that the minority developmental disability movement now needs. The black universities must recruit and provide manpower, and become prime resources in the communities.

The movement needs black leaders with knowledge of developmental disabilities who are sensitive and committed to meeting the needs of black developmentally disabled persons. This knowledge is a must in the helping professions such as law, the healing arts, education, and social services. A valuable resource can also be found in the University Affiliated Facilities of which there are 35 in the country. In its October, 1976 report, the University Affiliated Facilities Long Range Planning Task Force pointed out that interdisciplinary training is a basic essential in the effort to prepare leaders and other personnel to work effectively with the complex problems associated with mental retardation and other types of developmental disabilities. The Black universities must begin to forge a network of organizations such as state protection and advocacy systems, state mental health administrations, state developmental disabilities councils as well as private industry, volunteer advocacy groups and coalitions of concerned citizens. Establishing and monitoring such a network of linkages between the various groups will, in effect, create a force that must be dealt with. Let's not rely on someone else's safety net, but instead create our own network - a spider web that is light, flexible, yet possessed of enormous tensile strength. The black universities must become information centers for the assembling, ordering, and dissemination of information on developmental disabilities and become the "think tanks" for the minority developmental disabilities movement. The design of the developmental disabilities curriculum must serve not only students and researchers but parents, para-legals, para-professionals and cadres of volunteers. The black universities must reach out and make real and meaningful to all the laws and regulations currently on the books that serve developmentally disabled persons. The black universities must be clearinghouses of information about resources and services that exist and become a focal point for the needs of the communities in which they reside.

It is vital that this project succeed, a success here will provide incentives and motives for other projects and replication of this one, and the ripple effect will spread throughout the country. I have personally received letters from more than 48 black colleges indicating enthusiastic interest in participating in this type of program. The minority developmental disabilities movement will benefit from the leadership and expertise that can be and must be provided by you, the concerned members of the black educational community.

Keynote Address for the Texas Workshop

presented by

Raymond F. Holmes, Ph.D.
Assistant Commissioner for Mental Retardation
Department of Mental Health and Mental Retardation
Commonwealth of Virginia

A Rubik's Cube of Service Delivery
Can We Solve The Puzzle?

Historical Perspectives

The record of how mental health concepts and services have been formulated and delivered to blacks and other minorities reveals how deeply an institution such as the mental health profession is embedded in general society.

In the south, there was generally little state provision for blacks. If slaves, they were taken care of by their owners, perhaps at less expense than when being hospitalized at the owner's expense. Eastern State Hospital at Williamsburg, Virginia, the first state mental hospital in which is now the United States, accepted free blacks from its founding in 1774. After the Civil War in 1869, a separate mental hospital exclusively for blacks, Central State Hospital, was established in Virginia, ultimately located in Petersburg, Virginia.

If no state hospital had room for an ill black person, he was often confined to jail or an almshouse. In the history of Central State Hospital in Virginia, the hospital's success was once measured by the jail's evacuation of blacks awaiting treatment. The north's record of accepting the black mentally ill was no better.

In 1840 the United States Government decided to enumerate the insane, partly out of concern over the rising number of asylum residents. This evidenced a strange discovery; the south had almost no insane blacks, but as one moved north the rate of insanity increased. Jean Boudin, the French geographer and statistician, seized this information and extrapolated from it suggesting that cold climates were destructive to the mental health of blacks. In Louisiana only one out of 4,310 blacks was insane; in Virginia one out of 1,309; in Pennsylvania one in 257; in Massachusetts one in 44; in Maine the figure was, at that time, an impressive one in 14.

These statistics of 1840 were used for a number of years to support the idea of slavery.[1]

White vs Black Teacher Attitudes

1. Blacks tended to come from larger cities and obtained their degrees from urban universities;
2. Forty-seven percent of the black teachers were under 35 and had a higher probability of being married;
3. Blacks tended to be more satisfied with their teaching experience, but this decreased as length of teaching experience increased;
4. White teachers wanted more realistic professional training, while blacks wanted more knowlege of subject matters;
5. White teachers attributed job dissatisfaction to student lack of ability, poor student motivation, and discipline problems, while the black teachers emphasized large classes, poor equipment, inadequate supplies, and improper curriculum.

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[1] Willie, C. V. (ED.). Racism and Mental Health, University of Pittsburgh Press, 1979.

6. Black teachers tended to see the children as happy, energetic, fun loving, while white teachers viewed these students as talkative, lazy, and rebellious.

In general, black teachers tended to emphasize inadequate physical conditions under which they worked and the attitude of black teachers in this study suggests more optimism and job-mindedness than the attitude of white teachers.[2]

National Developmental Disabilities Survey

This study was designed to assess the extent and nature of the services offered to the developmentally disabled and particularly to minority groups by various service organizations or agencies. A series of nationwide meetings with service consumers and parents of developmentally disabled persons across the United States was held, the vast majority being minority persons. A sample of 1,200 out of 23,817 agencies was studied. The findings suggest that minority persons are neither under nor overrepresented in the developmentally disabled movement. Minorities account for about 17 percent of the nation's population, 23 percent of agency clients, 20 percent of their employees, and 17 percent of their board members. Minorities, however, were not fully represented in the highest category of employment - administration - although they are overrepresented among outreach category.

As might be expected, urban catchment areas contain the highest percentages of minorities. In turn, urban agencies have a higher proportion of minorities who are developmentally disabled. As suspicioned, any agency's minority staff is positively correlated with the proportion of minorities in the catchment area and the agency's location.[3]

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[2] Gottlieb, D. Teaching and Students: The Views of Negro and White Teachers, Sociology of Education: 37: 345-53, 1964.

Overview of Community Mental Health Center Trends

In October, 1963, Congress and President Kennedy approved and activated the community-based mental health center. The purpose of these centers was to replace state run institutions which had been in place for over 150 years. Seven hundred-sixty facilities were created, located in every state and accessible to 50 percent or more of the population. These federally funded community health mental centers were to provide comprehensive community-based care to individuals most in need, at greatest risk, and without regard to race, color, creed, or ability to pay. Their role has been influential upon the whole mental health system of care in the United States.

Since 1975 several salient community mental health center shifts in service delivery have been noted, for example:

1. Shifts have occurred from inpatient to outpatient care.
2. Between 1972-1976 federally funded community mental health centers increased by 78.9 percent, and their staffs grew from 24,655 to 48,466, a 96.5 percent increase.
3. Psychologists increased during this period by 151 percent, MSWs by 122 percent, administrative and maintenance staff by 199 percent, paraprofessional staff by 31 percent, RNs by 69 percent, and psychiatrists by 45 percent.

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[3] Morgan, S. The Developmental Disabilities Movement: A National Study of Minority Participation, Department of Health and Human Services, #54-p-71193/9-02.

4. It is apparent from the data that community mental health center leadership is moving from doctoral to non-doctoral staff.
5. A new population of chronically mentally ill patients has been observed ranging usually in age from 18 to 35 with histories of schizophrenia, affective disorders, organic psychosis, alcoholism and drug abuse, and personality disorders.

Since these patients do not meet the criteria for involuntary commitment codes, they are admitted under voluntary procedures and have short periods of stay but often relapse and reenter community health centers at a great expense. Their behavior is prone to violence, and most, though help-seeking are help-rejecting. Unfortunately, neither state hospitals nor community mental health centers are able to serve these individuals adequately.

If they wish to survive, community mental health centers must:

1. Develop closer relationships with clinics, hospitals, and medical centers;
2. Become more competitive in the private health care sector;
3. Continue to care for the indigent mentally ill, the poor and near poor; and
4. Become more adept at participating in third-party insurance programs, particularly Medicaid and Medicare.[4]

As budgets shrink, community mental health centers will be forced to decrease the size of their staffs, which may necessitate increased use of professionals rather than paraprofessionals.

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[4] Winslow, W.W. Changing Trends in Community Mental Health Centers: Keys to Survival in the Eighties, Hospital and Community Psychiatry: 33: 273-281, 1982.

A Few Trends in Mental Retardation Services

Intermediate Care Facilities/MR, as the predominant federal source of funding have had some undesirable side effects in terms of the states' efforts to build a balanced array of alternative residential and support services for the mentally retarded. The consequences of cutting funding for one element of a states' service continuum would be to slowdown development of community alternatives. Community services, while usually more normalizing, probably will not be less expensive for the states to operate. The Rehabilitation Act, 94-142, probably will survive the present efforts by the Feds to water down their powers. Home care subsidy for families may gain more favor in the various states. There will be continuing efforts to determine cost benefits or programs, and the zero-based budgeting approach will gain more support. Large training centers will begin to serve more of the medically mentally retarded disabled and serve as the temporary controlled environment for hyperactive mentally retarded persons. More interagency efforts will probably be demonstrated as budgets begin to shrink.

In a longitudinal study of Pennhurst where the 1,155 clients in 1977 were to be deinstitutionalized by court order, the following has been found:

1. Placement of more handicapped individuals into the community can be done, but must be accompanied by an array of medical and behavioral support services, case management, parental involvement, and intense training during the first crucial months in the community.

2. Dissatisfied parents of institutionalized persons - especially in alliance with employee unions - can be a potent force against deinstitutionalization.
3. The Hearing Master process is a valuable means of providing a forum for parents and relieving some of their anxieties regarding community placement.
4. Phased deinstitutionalization should be accompanied by a thorough plan that involves the participation of all key actors.[5]

In order to begin the task of solving the Rubik's cube puzzle of service delivery, I have shared with you a historical perspective and commented briefly on current trends in mental health and mental retardation. In conclusion, I would like to be bold and suggest several recommendations which I believe will assist in the solving of this most complex puzzle.

Recommendations

1. Restate the purpose with clarity and integrity, fully recognizing the risks involved in this task.
2. Reorder priorities in ways that support the stated purposes.
3. Reformulate policies in ways that eliminate reliance on unexamined past practices.
4. Reexamine programs and look at them in terms of their consistency with statements of mission and concern for quality.
5. Reconceptualize programs in ways that reflect the needs of students, as well as competencies of faculties.

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[5] Conroy, J. W.: The Pennhurst Longitudinal Study What Has Been Learned To Date? Prepared under contract of the United States Department of Health and Human Services, Office of Human Development Services, October 26, 1981.

6. Reassess processes to eliminate that which is blatantly unfair, demeaning, and dehumanizing.
7. Reevaluate personnel in terms of current specific missions and tasks.[6]

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[6] Kelly, J. Challenge and Choice: Business as Usual or Unusual Business. Paper presented at the meeting of the College of Preceptors (London), October, 1981.

Keynote Address for the Virginia Workshop

presented by

Walter Barwick, Ph.D.
Deputy Director, White House Initiative on
Black Colleges and Universities, U.S. Department
of Education, Washington, D.C.

"Linkers Do It Better Together"
Networking: A Systematic Response for Developmentally Disabled Clients

A Frill has been defined as any innovative program which isn't your priority. Reaganomics has resulted in many essential programs being defined as frills. The realization that fewer resources will be available to fund critical human needs has in many instances altered the expectations of service providers. Without cooperation between service providers, service expectations will continue to decline. The Gloom and Doom Syndrome is found in epidemic proportions as educators, social workers, correction workers and others outside the Defense Department view the shifting of resources within the bureaucracy of the Public Sector.

The New Federalism is viewed by some observers as the Old Colonialism and the change from categorical to block grants is perceived as positive or negative dependent upon your politics and/or perspective. Regardless of politics, Fatalism as a strategy is generally non-productive. If service providers view the situtation as inevitable and irreversible and consequently fail to generate theories, establish plans of action and implement plans based upon existing resources, the situation for individuals with developmental disabilities will be fatal with the legacy of survival limited to a lucky few. As service providers, we have a responsibility to improve those odds; a responsibility which requires a change in fatalistic behavior. Cooperative programming and networking require a change in service provision.

Change requires a disruption in the present pattern of behaviors. It involves risks as one is changing the known for the unknown. Change is viewed initially as the avoidance of pain and/or the seeking of pleasure. Change is needs based. Educators are generally resistant to change for change's sake. Networking, however, can be an effective response to not only those individuals who fall through the "safety net," but the one out of four individuals who is classified as developmentally disabled will be able to be better served.

The awareness of the problem creates the need for change. The generation of alternatives and the selection of appropriate alternatives created the mean for change. Networking requires planned action.

Developmental Disabilities have been difficult to define because of the diversity of conditions which comprise this category. 94-142 and the Rehabilitation Act of 1973 attempt to describe the varied categories and to limit the number of individuals who are included under this category. Networking provides a means for continuity on the local level, a continuity of definition and service provision.

It is clearly indicated that developmental disabilities become most prevalent while the child is in the formative years, specifically in pre-school - grade 4. Individuals who are people of color are oftentimes classified as mentally retarded, while the white child is called learning impaired.

The Rehabilitation, Comprehensive Services and Developmental Disabilities legislation called for defining developmental disabilities in terms of functional as opposed to categorical criteria and requiring states to target resources.

One out of each four persons in this audience could be potentially labeled developmentally disabled. One out of four persons could have a disability which affects one or more of your life's major activities and which constitutes or results in a substantial handicap to employment and/or independent living. How does a state effectively target funds for individuals whose disabilities originate in childhood and are attributable to mental retardation, cerebral palsy, epilepsy, autism, specific learning disabilities, i.e. reading, encoding and certain other neurological conditions? The state can effectively do so with community input and networking.

Current issues evolve from problems in appropriately labeling students due to inadequate measures and conscious mislabeling, inadequate funding base for the population, and limited use of innovative techniques. The prognosis will be determined by the providers' response to challenge. Can networking really work?

Networking requires a change in behavior, a change agent who is aware of the need to creatively deal with limited resources to impact on a massive population, the developmentally disabled. A change agent, also, has the responsibility to educate the community as a first step in problem resolution. The change agent plays an advocacy role which interferes with the perpetuation of the Fatalism strategy.

The change agent in his advocacy role not only advocates networking, but the strategies which make networking a feasible way to creatively use limited resources. The delivery system is a critical component of the networking process.

- Consortia, a composite effort by two or more colleges and/or universities is now a familiar means of delivering service to a specific population. The developmentally disabled might be serviced in such a manner.
- Partnerships might also be established between colleges or with local education agencies who service the elementary and secondary students.
- Cooperative Agreements might be established with the private sector and/or other Human Service Agencies who are committed to serving this population. Cooperative agreements are mutually beneficial arrangements which clearly delineate what human and fiscal resources are to be allocated, the benefits to accrue to each party, and the manner in which the service will be provided.
- Subcontracting of services can be a cost effective way of providing services to the developmentally disabled. Subcontracting on a consistent basis allows for appropriate staffing, continuity of service and creates an evolving expertise. Subcontracting might, also, be utilized in consortia, partnerships and cooperative agreements. The overlapping of service needs and strategies to meet those needs creates the climate for networking, establishing links. Linkers do it together, because to do otherwise is to create gaps in service.
- Multi-funding of programs, also, contributes to the positive climate for networking and enables the participants to provide a quality of service which would not otherwise be possible.

Some of the Federal departments or programs which include services to the disabled along with other groups are:

- Social Security Disability Insurance (SSDI)
- Aid to Families with Dependent Children (AFDC)
- Social and Rehabilitative Services
- Crippled Children's Services
- Health Services and Mental Health Administration
- Maternal and Infant Care
- Community Mental Health Centers
- Education for the Handicapped State Grants
- Developmental Disabilities State Grants
- Department of Housing and Urban Developments' Section 202 Direct Loan and Section 8 Rent Subsidy programs
- Mental Health System Act
- Title XX Social Services State Grants
- Vocational Rehabilitation State Grants
- Medicaid including the Intermediate Care Facilities for the Mentally Retarded funding for small community residence
- Rehabilitation Services Administration
- Bureau of Indian Affairs
- Office for Civil Rights
- Maternal and Child Health Service

In closing, remember: "Linkers Do It Better Together."

Analysis: Pre and Post-Tests

In assessing the knowledge base of the workshop participants, a Pre-Test was designed by the Project Evaluation Team chaired by Dr. William D. Lawson. Other Evaluation Team members were Drs. Melvin Davis, James H. Hicks, Hoyt Taylor, and Francis Taylor.

Administered at the beginning of Session I, the Pre-Test was designed to determine the extent of the participants' knowledge of developmental disabilities and the various disciplines which impart knowledge and develop skills relevant for working with developmentally disabled individuals. Upon completion of the 15 hour program design, a Post-Test was administered during Session V. Participants were asked to rate their knowledge base on 13 factors on a scale of 1 to 5 with 1 indicating very weak and 5 very strong. Included among those factors were knowledge of the meaning of developmental disabilities, special knowledge and skills your discipline/professions offers to assist developmentally disabled individuals, mini-team approach to working with developmentally disabled individuals, and manpower needs in the service delivery system.

Tables 4 through 7 present the distribution of scores for the tests for each of the three workshops. An analysis of the differences between the means for the pre-tests and post-tests reveals significant changes in the knowledge acquired relative to the various factors that were measured. Relative to the mini-team approach to working with DD clients, the differences between the means within workshop groups ranged from 1.6 to 1.95, moving from a weak knowledge base to a strong one in each instance. Likewise significant were the differences between means across groups on knowledge of manpower needs in the DD service delivery system whereby the differences ranged from 1.44 to 1.64 moving again from weak to strong.

With improvements on each of the 13 factors, the need for the lead role assumed by ACHE was further documented and emphasis areas for continued concentration were identified. At the same time, the data revealed that the purposes of the workshops were met.

Table 4

Distribution of Scores for Pre-Test and Post-Test

Alabama Workshop

Knowledge Base		Very Weak (1)	Weak (2)	Moderate (3)	Strong (4)	Very Strong (5)	Total	Mean Score	D*
Meaning of Developmental Disabilities	Pre-Test		15.2%(5)	54.5%(18)	24.2%(8)	6.1%(2)	100%(33)	3.21	
	Post-Test			3.1%(1)	50%(16)	46.9%(15)	100%(32)	4.44	1.23
Handicaps Encompassed by the Label "Developmental Disabilities"	Pre-Test		15.2%(2)	45.5%(15)	30.3%(10)	9.1%(3)	100.1%(33)	3.33	
	Post-Test			9.4%(3)	62.5%(20)	28.1%(9)	100%(32)	4.19	.86
Legal Bases for Services and Facilities to Assist The Developmentally Disabled Individual	Pre-Test	6.1%(2)	30.3%(10)	42.4%(14)	15.2%(5)	6.1%(2)	100.1%(33)	2.85	
	Post-Test		3.1%(1)	18.8%(6)	37.5%(12)	40.6%(13)	100%(32)	4.16	1.31
Special Knowledge and Skills Your Discipline/Profession Offers to Assist Developmentally Disabled Individuals	Pre-Test	3.0%(1)	6.1%(2)	39.4%(13)	33.3%(11)	18.2%(6)	100%(33)	3.58	
	Post-Test			15.6%(5)	25%(8)	59.4%(19)	100%(32)	4.44	.86
Various Disciplines/Professions Which Foster Knowledge and Skills Essential for Assisting Developmentally Disabled Individuals	Pre-Test	3.1%(1)	9.4%(3)	56.3%(18)	28.1%(9)	3.1%(1)	100%(32)	3.09	
	Post-Test			12.5%(4)	53.1%(17)	[illegible]4%(11)	100%(32)	4.22	1.13
Mini Team (Systems) Approach to Working With Developmentally Disabled Individuals	Pre-Test	9.1%(3)	39.4%(13)	33.3%(11)	9.1%(3)	9.1%(3)	100%(33)	2.70	
	Post-Test			6.3%(2)	37.5%(12)	56.3%(18)	100.1%(32)	4.50	1.80

Table 4(continued)

Distribution of Scores for Pre-Test and Post-Test

Alabama Workshop

Knowledge Base		Very Weak (1)	Weak (2)	Moderate (3)	Strong (4)	Very Strong (5)	Total	Mean Score	D*
Developmental Disability Client Population	Pre-Test	3.2%(1)	22.6%(7)	54.8%(17)	16.1%(5)	3.2%(1)	99.9%(31)	2.94	
	Post-Test			16.1%(5)	35.5%(11)	45.2%(14)	99.9%(31)	4.23	1.29
Local Agencies Serving The Developmentally Disabled	Pre-Test	9.1%(3)	21.2%(7)	42.4%(14)	9.1%(3)	18.2%(6)	100%(33)	3.06	
	Post-Test		9.4%(3)	21.9%(7)	28.1%(9)	40.6%(13)	100%(33)	4.00	.94
State Agencies Serving The Developmentally Disabled	Pre-Test	9.4%(3)	15.6%(5)	43.8%(14)	25%(8)	6.3%(2)	100.1%(32)	3.03	
	Post-Test		3.1%(1)	25%(8)	43.8%(14)	28.1%(9)	100%(32)	3.97	.94
Federal Agencies Serving The Developmentally Disabled	Pre-Test	9.1% (3)	33.3%(11)	45.5%(15)	12.1%(4)		100%(33)	2.61	
	Post-Test		9.7%(3)	29%(9)	38.7%(12)	22.6%(7)	100%(31)	3.74	1.13
Funding Sources That May Assist in the Preparation of Personnel for Working in the Developmental Disability Service Delivery System	Pre-Test	12.1%(4)	39.4%(13)	36.4%(12)	12.1%(4)		100%(33)	2.48	
	Post-Test		6.3%(2)	37.5%(12)	34.4%(11)	21.9%(7)	100.1%(32)	3.48	1.36
Manpower Needs in the Developmental Disability Service Delivery System	Pre-Test	9.1%(3)	36.4%(12)	33.3%(11)	18.2%(6)	3%(1)	100%(33)	2.70	
	Post-Test			18.8%(6)	28.1%(9)	53.1%(17)	100%(32)	4.34	1.64
Job Classifications in The Developmental Disability Service Delivery System Relevant To Your Discipline	Pre-Test	9.1%(3)	30.3%(10)	45.5%(15)	12.1%(4)	3%(1)	100%(33)	2.70	
	Post-Test			6.3%(2)	50%(16)	43.8%(14)	100.1%(32)	4.38	1.68

*D = Difference Means for Pre-Test and Post-Test

Table 5

Distribution of Scores for Pre-Test and Post-Test

Texas Workshop

Knowledge Base		Very Weak (1)	Weak (2)	Moderate (3)	Strong (4)	Very Strong (5)	Total	Mean Score	D*
Meaning of Developmental Disabilities	Pre-Test	3.7%(1)	3.7%(1)	66.7%(18)	18.5%(5)	7.4%(2)	100%(27)	3.22	
	Post-Test			17.9%(5)	53.6%(15)	28.6%(8)	100.1%(28)	4.11	.89
Handicaps encompassed by The Label "Developmental Disabilities"	Pre-Test	3.7%(1)	14.8%(4)	40.7%(11)	37.0%(10)	3.7%(1)	99.9%(27)	3.22	
	Post-Test		7.1%(2)	14.3%(4)	50.0%(14)	28.6%(8)	100%(28)	4.00	.78
Legal Bases for Services and Facilities to Assist The Developmentally Disabled Individual	Pre-Test	11.1%(3)	29.6%(8)	37.0%(10)	22.2%(6)		99.9%(27)	2.70	
	Post-Test	3.6%(1)	3.6%(1)	35.7%(10)	28.6%(8)	28.6%(8)	100.1%(28)	3.75	1.05
Special Knowledge and Skills Your Discipline/ Profession Offers to Assist Developmentally Disabled Individuals	Pre-Test	11.1%(3)	14.8%(4)	48.1%(13)	22.2%(6)	3.7%(1)	99.9%(27)	2.93	
	Post-Test	3.6%(1)	3.6%(1)	14.3%(4)	53.6%(15)	2.5%(7)	100.1%(28)	3.93	1.00
Various Disciplines/ Professions Which Foster Knowledge and Skills Essential for Assisting Developmentally Disabled Individuals	Pre-Test	11.1%(3)	22.2%(6)	44.4%(12)	22.2%(6)		99.9%(27)	2.77	
	Post-Test	3.6%(1)		32.1%(9)	46.4%(13)	17.9%(5)	100%(28)	4.07	1.30
Mini Team (Systems) Approach to Working With Developmentally Disabled Individuals	Pre-Test	18.5%(5)	44.4%(12)	29.6%(8)	7.4%(2)		99.9%(27)	2.19	
	Post-Test		3.6%(1)	10.7%(3)	53.6%(15)	32.1%(9)	100%(28)	4.14	1.95

Table 5(continued)

Distribution of Scores for Pre-Test and Post-Test

Texas Workshop

Knowledge Base		Very Weak (1)	Weak (2)	Moderate (3)	Strong (4)	Very Strong (5)	Total	Mean Score	D*
Developmental Disability Client Population	Pre-Test	11.1%(3)	29.6%(8)	33.3%(9)	22.2%(6)	3.7%(1)	99.9%(27)	2.77	
	Post-Test		11.1%(3)	22.2%(6)	40.7%(11)	25.9%(7)	99.9%(27)	3.81	1.04
Local Agencies Serving The Developmentally Disabled	Pre-Test	11.1%(3)	29.6%(8)	29.6%(8)	25.9%(7)	3.7%(1)	99.9%(27)	2.81	
	Post-Test	3.6%(1)	7.1%(2)	21.4%(6)	50%(14)	17.9%(5)	100%(28)	3.71	.90
State Agencies Serving The Developmentally Disabled	Pre-Test	7.4%(2)	33.3%(9)	37%(10)	18.5%(5)	3.7%(1)	99.9%(27)	2.77	
	Post-Test	3.7%(1)	7.4%(2)	22.2%(6)	48.1%(13)	18.5%(5)	99.9%(27)	3.70	.93
Federal Agencies Serving The Developmentally Disabled	Pre-Test	11.5%(3)	34.6%(9)	34.6%(9)	19.2%(5)		99.9%(26)	2.62	
	Post-Test		10.7%(3)	42.9%(12)	32.1%(9)	14.3%(4)	100%(28)	3.50	.88
Funding Sources that May Assist in the Preparation of Personnel for Working in the Developmental Disability Service Delivery System	Pre-Test	25.9%(7)	51.9%(14)	18.5%(5)	3.7%(1)		100%(27)	2.00	
	Post-Test	3.6%(1)	25%(7)	32.1%(9)	28.6%(8)	10.7%(3)	100%(28)	3.17	1.17
Manpower Needs in the Developmental Disability Service Delivery System	Pre-Test	25.9%(7)	44.4%(12)	14.8%(4)	14.8%(4)		99.9%(27)	2.19	
	Post-Test	3.7%(1)	7.4%(2)	11.1%(3)	59.3%(1[illegible]	18.5%(5)	100%(27)	3.63	1.44
Job Classifications in The Developmental Disability Service Delivery System Relevant To Your Discipline	Pre-Test	40.7%(11)	29.6%(8)	11.1%(3)	14.8%(4)	3.7%(1)	99.9%(27)	1.96	
	Post-Test	3.6%(1)	14.3%(4)	17.9%(5)	53.6%(15)	10.7%(3)	100%(28)	3.54	1.58

*D= Difference Means for Pre-Test and Post-Test

Table 6

Distribution of Scores for Pre-Test and Post-Test

Virginia Workshop

Knowledge Base		Very Weak (1)	Weak (2)	Moderate (3)	Strong (4)	Very Strong (5)	Total	Mean Score	D*
Meaning of Developmental Disabilities	Pre-Test		23.5%(4)	58.8%(10)	5.9%(1)	11.8%(2)	100%(17)	3.06	
	Post-Test			26.7%(4)	53.3%(8)	20%(3)	100%(15)	3.93	.87
Handicaps Encompassed by The Label "Developmental Disabilities"	Pre-Test		17.6%(3)	47.1%(8)	29.4%(5)	5.9%(1)	100%(17)	3.24	
	Post-Test			35.3%(6)	47.1%(8)	17.6%(3)	100%(17)	4.40	1.16
Legal Bases for Services and Facilities to Assist The Developmentally Disabled Individual	Pre-Test	5.9%(1)	29.4%(5)	41.2%(7)	17.6%(3)	5.9%(1)	100%(17)	2.88	
	Post-Test			40%(6)	53.3%(8)	6.7%(1)	100%(17)	3.67	.79
Special Knowledge and Skills Your Discipline/ Profession offers to Assist Developmentally Disabled Individuals	Pre-Test		40%(6)	13.3%(2)	33.3%(5)	13.3%(2)	99.9%(15)	2.82	
	Post-Test		6.7%(1)	13.3%(2)	46.7%(7)	33.3%(5)	100%(15)	4.07	1.25
Various Disciplines/ Professions Which Foster Knowledge and Skills Essential for Assisting Developmentally Disabled Individuals	Pre-Test		35.3%(6)	41.2%(7)	23.5%(4)		100%(17)	2.88	
	Post-Test			26.7%(4)	40%(6)	33.3%(5)	100%(15)	4.07	1.19
Mini Team Approach to Working With Developmentally Disabled Individuals	Pre-Test	70.6%(12)	11.8%(2)	11.8%(2)	5.9%(1)		100%(17)	2.53	
	Post-Test		13.3%(2)	60%(9)	26.7%(4)		100%(15)	4.13	1.60

Table 6(continued)

Distribution of Scores for Pre-Test and Post-Test

Virginia Workshop

Knowledge Base		Very Weak (1)	Weak (2)	Moderate (3)	Strong (4)	Very Strong (5)	Total	Mean Score	D*
Developmental Disability Client Population	Pre-Test	11.8%(2)	64.7%(11)	11.8%(2)	11.8%(2)		100.1%(17)	3.24	
	Post-Test		7.7%(1)	61.5%(8)	30.8%(4)		100%(13)	4.23	.99
Local Agencies Serving The Developmentally Disabled	Pre-Test	23.5%(4)	58.8%(10)	5.9%(1)	11.8%(2)		100%(17)	3.06	
	Post-Test		46.7%(7)	33.3%(5)	20%(3)		100%(15)	3.73	.67
State Agencies Serving The Developmentally Disabled	Pre-Test	14.3%(2)	57.1%(8)	14.3%(2)	14.3%(2)		100%(14)	3.06	
	Post-Test	7.1%(1)	35.7%(5)	50%(7)	7.1%(1)		99.9%(14)	3.57	.51
Federal Agencies Serving The Developmentally Disabled	Pre-Test	47.1%(8)	41.2%(7)	11.8%(2)			100.1%(17)	2.65	
	Post-Test	6.1%(1)	33.3%(5)	46.7%(7)	13.3%(2)		100%(15)	3.67	1.02
Funding Sources That May Assist in the Preparation of Personnel for Working in the Developmental Disability Service Delivery System	Pre-Test	64.7%(11)	29.4%(5)	5.9%(1)			100%(17)	2.24	
	Post-Test	6.7%(1)	40%(6)	33.3%(5)	20%(3)		100%(15)	3.67	1.43
Manpower Needs in the Developmental Disability Service Delivery System	Pre-Test	52.9%(9)	35.3%(6)	11.8%(2)			100%(17)	2.59	
	Post-Test		13.3%(2)	66.7%(10)	20%(3)		100%(15)	4.07	1.48
Job Classification in The Developmental Disability Service Delivery System Relevant To Your Discipline	Pre-Test	33.3%(5)	40%(6)	26.6%(4)			99.9%(15)	2.59	
	Post-Test		33.3%(5)	40%(6)	26.7%(4)		100%(15)	3.93	1.34

*D = Difference Between Means for Pre-Test and Post-Test

Table 7

Distribution of Scores for Pre-Test and Post-Test

Combined Workshops

Knowledge Base		Very Weak (1)	Weak (2)	Moderate (3)	Strong (4)	Very Strong (5)	Total	Mean Score	D*
Meaning of Developmental Disabilities	Pre-Test	1%(1)	13%(10)	60%(46)	18%(14)	7.8%(6)	100%(77)	3.16	
	Post-Test			13%(10)	52%(39)	35%(26)	100%(75)	4.16	1.00
Handicaps encompassed by the label "Developmental Disabilities"	Pre-Test	1%(1)	12%(9)	48%(37)	33%(25)	7%(5)	100%(77)	3.26	
	Post-Test		3%(2)	17%(13)	55%(42)	26%(20)	100%(77)	4.19	.93
Legal bases for services and facilities to assist the developmentally disabled individual	Pre-Test	8%(6)	30%(23)	40%(31)	18%(14)	4%(3)	100%(77)	2.82	
	Post-Test	1%(1)	3%(2)	29%(22)	36%(28)	29%(22)	98%(77)	3.86	1.04
Special Knowledge and skills your discipline/profession offers to assist developmentally disabled individuals	Pre-Test	5%(4)	16%(12)	37%(28)	29%(22)	12%(9)	99%(75)	3.11	
	Post-Test	1%(1)	3%(2)	15%(11)	40%(30)	41%(31)	100%(75)	4.14	1.03
Various Disciplines/professions which foster knowledge and skills essential for assisting developmentally disabled individuals	Pre-Test	5%(4)	20%(15)	49%(37)	25%(19)	1%(1)	100%(76)	2.91	
	Post-Test	1%(1)		23%(17)	48%(36)	28%(21)	100%(75)	4.12	1.93
Mini Team (systems) approach to working with developmentally disabled individuals	Pre-Test	26%(20)	35%(27)	27%(21)	8%(6)	4%(3)	100%(77)	2.47	
	Post-Test		4%(3)	19%(14)	41%(31)	36%(27)	100%(75)	4.25	1.78

Table 7(continued)

Distribution of Scores for Pre-Test and Post-Test

Combined Workshops

Knowledge Base		Very Weak (1)	Weak (2)	Moderate (3)	Strong (4)	Very Strong (5)	Total	Mean Score	D*
Developmental Disability Client Population	Pre-Test	8%(6)	35%(26)	37%(28)	17%(13)	3%(2)	100%(75)	2.95	
	Post-Test		6%(4)	27%(19)	37%(26)	30%(21)	100%(71)	4.09	1.14
Local agencies serving the Developmentally Disabled	Pre-Test	13%(10)	33%(25)	30%(23)	16%(12)	9%(7)	100%(77)	2.98	
	Post-Test	1%(1)	16%(12)	24%(18)	34%(26)	24%(18)	99%(76)	3.81	.83
State agencies serving the Developmentally Disabled	Pre-Test	10%(7)	29%(22)	36%(26)	21%(15)	4%(3)	100%(73)	2.95	
	Post-Test	3%(2)	11%(8)	29%(21)	38%(28)	19%(14)	100%(73)	3.75	.80
Federal agencies serving the Developmentally Disabled	Pre-Test	18%(14)	36%(27)	34%(26)	12%(9)		100%(76)	2.63	
	Post-Test	1%(1)	15%(11)	38%(28)	31%(23)	15%(11)	100%(74)	3.64	1.01
Funding Sources that may assist in the preparation of personnel for working in the developmental disability service delivery system	Pre-Test	29%(22)	42%(32)	23%(18)	7%(5)		101%(77)	2.57	
	Post-Test	3%(2)	20%(15)	35%(26)	29%(22)	13%(10)	100%(75)	3.44	.87
Manpower needs in the developmental disability service delivery system	Pre-Test	25%(19)	39%(30)	22%(17)	13%(10)	1%(1)	100%(77)	2.49	
	Post-Test	1%(1)	5%(4)	26%(19)	38%(28)	30%(22)	100%(74)	4.01	1.52
Job classifications in the Developmental Disability Service Delivery System Relevant to your Discipline	Pre-Test	25%(19)	32%(24)	29%(22)	11%(8)	3%(2)	100%(75)	2.42	
	Post-Test	1%(1)	12%(9)	17%(13)	47%(35)	23%(17)	100%(75)	3.95	1.53

D* = Mean Difference for Pre-Test and Post-Test

Training Manual

Workshop participants were provided a Training Manual as part of the registration packet. Prepared in a leather bound loose leaf filler, the Training Manual was designed as both a training guide and a resource book. Prepared by Dr. Theodore Childs, Mrs. Marie L. Moore, Dr. Francis Taylor and Mrs. Naomi Hunt all from Tuskegee Institute, the Manual provided a comprehensive summary of developmental disabilities.

- Section I - Needs and Resources: Specific client populations, manpower needs and available resources in the DD system were identified.
- Section II - Scope of Developmental Disabilities: Provided information on federal legislation, service delivery systems, normalization theory and deinstitutionalization, legal concept, service delivery concept, and other topics.
- Section III - Curriculum Development: Emphasis on developing methods of adopting or redesigning course materials, content, methods, field experiences, etc. to enhance curriculum for minorities relative to developmentally disabled populations.
- Section IV - Interinstitutional Cooperation: Reviews the major types of interinstitutional cooperative arrangements and discusses some limitations of cooperative arrangements.
- Selected Bibliography

Workshop Participants

Faculty representing the core disciplines and professional areas from 75 HBCU's were invited to participate in one of the three workshops. Faculty participants were contacted via letters of invitation extended to Presidents of the institutions, and informational leaflets and packets of information distributed by the Vice Presidents/Deans for Academic Affairs. Table 8 reflects the distribution of faculty participants by state and workshop.

Table 8

Faculty Participants by State and Workshop

Workshop	State	No. 4 Year HBCU's	Participating	No. Faculty Attending
ALABAMA	Alabama	7	7	23
	Florida	4	2	4
	Georgia	8	5	9
	Tennessee	6	3	8
TEXAS	Arkansas	3	2	2
	Louisiana	5	2	5
	Mississippi	5	4	7
	Oklahoma	1	1	3
	Texas	8	4	11
VIRGINIA	Kentucky	1	1	1
	North Carolina	10	2	8
	New Jersey	-	1	2
	Pennsylvania	2	1	1
	South Carolina	6	3	3
	Virginia	4	2	3
	Others	5	-	-
TOTALS		75	38	90

WORKSHOP EVALUATION

The Workshop Participant Evaluation Form was designed to obtain information from participants regarding the effectiveness of the workshop. Participants were asked to rate the pre-registration package, keynote speaker, film, and the breakout sessions (Teams I, II, and III) on a scale of 1 to 10 with 1 indicating the lowest rating and 10 the highest rating. Comments were solicited regarding each of these components of the workshop. Further, participants were asked to indicate whether the workshop provided any new ideas or broadened their understanding of the DD service delivery system and to indicate their feelings regarding whether their institutions would develop personnel preparation programs in one of the areas serving the developmentally disabled. Finally, participants were asked to make suggestions for improving future workshops.

Alabama Workshop

The evaluation data indicate that the workshop was highly successful in achieving its preliminary goal of increasing participants' awareness and understanding of the DD service delivery system and of the need for black colleges and universities to provide programs to enhance the number of minority professionals serving the developmentally disabled.

All of the participants completing the evaluation form indicated that the workshop provided them with new ideas and broadened their understanding of the DD service delivery system. Eighty-two percent of the respondents expressed the feeling that their institutions would implement a personnel preparation program in one of the areas serving the developmentally disabled.

In assessing the various components of the workshop, the participants rated all of the components very high with the exception of the film. The film only received a fair rating. The keynote speaker received the highest rating among the components. The mean (average) ratings for the workshop components are as follows: pre-registration package (8.2); keynote speaker (9.3); film (7.1); Team I (8.8); Team II (8.1); Team III (8.6); and overall team performance (8.5). Although the film received the lowest rating, it is important to note that the majority (58.3%) of the participants who viewed the film gave it a rating of 8 or above.

Texas Workshop

9

All of the participants completing the evaluation form indicated that the workshop provided them with new ideas and broadened their understanding of the DD service delivery system. Eighty-one percent of the respondents expressed the feeling that their institutions would implement a personnel preparation program in one of the areas serving the developmentally disabled.

In assessing the various components of the workshop, the participants' ratings ranged from fair to good. The film received the lowest rating and the pre-registration received the highest rating. The mean (average) ratings for the workshop components are as follows: pre-registration package (8.44); keynote speaker (7.85); film (7.00); Team I (7.93); Team II (8.00); Team III (8.12); overall team performance (8.01).

Virginia Workshop

All of the participants completing the Participant Evaluation Form indicated that the workshop provided them with new ideas and broadened their understanding of the DD service delivery system. Eighty-one percent of the respondents expressed the feeling that their institutions would implement a personnel preparation program in one of the areas serving the developmentally disabled.

In assessing the various components of the workshops, the participants gave very high ratings to all of the components with the exception of two. The mean (average) ratings of the components are as follows: pre-registration package (9.44); keynote speaker (7.69); film (6.75); Team I (8.94); Team II (9.13); Team III (9.00); and overall team performance (9.02). It is obvious from these scores that the teams performed very well, and given the expertise of many of the participants, the mini team trainers should be very pleased with ratings.

Comments Across Workshops

> "This was one of the few conferences I have attended that provided so much valuable information that may be utilized by several disciplines."

> "Timing needs working on. In my opinion we could have used more time for these sessions. All teams were good. Enough time was not allowed for dialogue."

> "Excellent planning and preparation were evident in all aspects."

> "Hassle-free neatly packaged; well prepared."

> "Some participation activities may have added to the carry-over value."

> "The film was very good in terms of illustrating the holistic approach to DD."

> "Film was good, but too long."

"The mini sessions were very helpful in providing information concerning how the DD related disciplines could work cooperatively in providing services to DD populations."

Suggestions for Improving Workshops

"Establish a network for sharing resources (i.e. information, materials, staff, etc.)."

"Expand the time of the workshops and include follow-up sessions."

"Provide for an open discussion on the feasibility of new program directions in the current atmosphere of budget cuts and the new federalism."

"There should be sessions where participants can exchange information about what they are doing at their institutions to expose students to the developmental disabilities field."

"Include counselors, mental health workers and other personnel from developmental agencies."

"Administrators should be invited to attend the workshops because in many cases programs are difficult to initiate unless they are introduced by the administration."

"Provide for an examination of the attractiveness of jobs in the DD system in relation to the time and money consumed in earning appropriate credentials."

80

WORKSHOP OUTCOMES

Procedure for Developing Institutional Plans

The participants were grouped according to the institutions that they represented and then requested to develop plans that they would be willing to take back to their respective campuses and share with fellow faculty members and academic administrators and then seek to have them implemented at the earliest possible date.

Each of the groups was provided a Curriculum Development Planning Form on which to indicate objectives, activities to achieve objectives, and the expected date of initiation and completion of activities. The group members selected a facilitator and proceeded with the development of the plans. During the planning sessions, members of the Mini-Training Team visited with the groups to offer advice and assistance where appropriate. After the plans were completed, individual group reports were made orally and each group received feedback from the Mini-Training Team and other participants in the respective workshops.

Curriculum Enhancement Plans

One of the major programmatic activities of the workshops involved participants developing curriculum enhancement plans that their respective institutions could reasonably implement in order to better prepare students for careers in the field of developmental disabilities. To insure the success of this activity and provide participants with a common base of information for formulating the plans, a training manual was disseminated to participants which included basic background information on the nature and scope of developmental disabilities, disciplines that are relevant for training personnel to work with developmentally disabled populations, and curriculum enhancement strategies. In addition, the Developmental Disabilities Mini-Training Team consulted with participants in small sessions on alternative ways of building developmental disabilities content into the curricula of the disciplines which share responsibility for the training of personnel to service clients with developmental disabilities.

The curriculum enhancement strategies that were reviewed with participants included the following: change in course content/emphasis; development of new courses; interdisciplinary course teaching; field trips to developmental disabilities service sites; field placements and internships; and guest lectures. Also participants were acquainted with some interinstitutional cooperative mechanisms which could be employed by historically black colleges and universities to develop course content and training programs in the field of developmental disabilities.

The curriculum enhancement plans were quite diverse reflecting the relative development of programs unique to developmental disabilities content already included in the curricula. However, most of the institutions developed plans with emphasis on building developmental disabilities content in present course offerings. Twelve institutions indicated plans to develop new courses specifically focusing on developmental disabilities and ten of the institutions had plans to promote interdisciplinary course teaching so as to insure that their students developed an understanding of the interdisciplinary nature of work in the developmental disabilities service delivery systems.

Several of the institutions formulated plans to establish linkages with developmental disabilities service agencies in their locale for the purpose of exposing students to the practical aspect of work with developmentally disabled populations through field trips, field placements and internships, and bringing resource persons to their campuses to address students and faculty. A few of the institutions developed plans to pursue and hopefully establish cooperative relationships with other institutions in order to offer their students access to programs such as physical therapy, nursing, nutrition, and occupational therapy that were not available on their campuses.

Overall, the curriculum enhancement plans indicated that the participants had developed a deep awareness of the contributions that their institutions could make toward preparing more minority professionals for careers in the field of developmental disabilities. Further, the plans suggested that participants recognized the importance of utilizing existing resources (i.e., faculty, programs, developmental disabilities service agencies, and practitioners) at their disposal to provide students with the knowledge, skill, and value competencies required for work with developmentally disabled populations. Finally, the plans indicated that participants recognized the difficulty involved in making major curriculum changes or establishing new programs and thus placed more emphasis on building developmental disabilities content into present course offerings in those disciplines from which professional personnel are recruited for work in the field of developmental disabilities.

Developing New Courses

New courses can be introduced into already existing curricula. The emphasis on developmental disabilities can be applied to almost all professional and educational areas. For example, the social science department of many universities can institute a course which is geared to addressing the issues that plague parents of handicapped children. Content could include: identifying local service delivery agencies, counseling, explaining their rights and informing them of laws that were designed with them in mind. The area of adoption and foster care of the developmentally disabled could also be explored in such a course. Departments of education could initiate a course geared to addressing the problems incurred in an educational setting with developmentally disabled children and adults. The content could include special techniques and equipment needed to foster a positive learning experience, an overview of the educational needs of the developmentally disabled, methods of mainstreaming these special-needs children into the classroom, etc. The physical education department has many avenues of introducing the needs of the developmentally disabled into the curriculum. The areas to be explored include: adaptive physical education classes, special equipment, and identifying the special physical needs of the developmentally disabled.

The above three are just brief examples of how a new course would fit into a pre-existing curriculum.

Interdisciplinary Course Teaching/Learning

Pooling of resources is not a new idea, and the interdisciplinary approach is a method of pooling resources and ideas. This educational approach entails two or more departments designing and implementing a course that would serve the needs of students with different majors. An example of an interdisciplinary course could be one which is sponsored by the departments of special education and psychology. In such a course, the content could include: discussion of evaluative tools used to measure performance levels and the proper use and interpretation of these tools. The psychological needs and the educational needs of the developmentally disabled can be discussed and a correlation drawn between them.

Another example of an interdisciplinary course could be one which is shared by the departments of nutrition, psychology and nursing. Here, the commonality is that the general health of the child is important to his psychological wellbeing. The nutritionist may have information on the effects of various foods on behavior and health. Many developmentally disabled have feeding (eating) problems that could be worked on collectively by the nurse, nutritionist and psychologist.

Change in Course Content/Emphasis

Initiating a new course on campus is not always easily obtainable. However, changing the content of an already existing course may be more easily accomplished. Most curricula have in place a course that could be modified to include a developmental disabilities component. Nursing departments could include segments addressing the needs of the developmentally disabled while hospitalized. The nutritionist could include a portion geared to the special nutritional needs of children and adults with feeding difficulties. The psychology department could include a component on the validity of standardized tests. The social work department could address the problem of deinstitutionalization and community placement.

This need not be a full course on developmental disabilities, but should afford exposure to the developmental disabilities system; and courses such as these will give exposure to some of the opportunities available.

Field Trips

This type of exposure is long lasting and quite valuable. There is no substitute for observing in real life what has been discussed in the textbook. All disciplines can usually arrange for a tour of a facility and talk with the persons from their disicplines about the everyday function, organization and problems incurred with the developmentally disabled population. Places of interest will depend upon the discipline. Nursing students may visit childrens hospitals, state crippled childrens agencies and schools for the handicapped. Social work students may want to visit residential facilities and community based programs. Psychology students may visit residential facilities, vocational rehabilitation centers and schools for the handicapped. These are just a few places to visit in your community. Your community may have all or more of these sites.

Field Placement Arrangements/Internships

Many of our professions require "X" amount of hours spent in a practicum where the student gets the opportunity to practice clinically what he/she learned in the classroom environment. Placement of students in the developmental disabilities system is an excellent vehicle of promoting understanding of the topic while gaining experience.

Field placements should match the student's interest and competency level to the offerings of the field placement site. Field placements traditionally are offered to students who are in the midst of obtaining theoretical knowledge from the educational or academic institution. The internship is usually offered to students who have completed their academic requirements and are ready to start practicing their profession. In this situation, emphasis is placed on "doing;" and quite often, the student will be required to carry a full caseload or be completely responsible for some area of practice.

The student of special education, physical education, social work, psychology, recreation, nursing, nutrition, speech, physical and occupational therapy can use a residential facility as a field placement or internship site. Other sites that may be used include: local schools, group homes, child welfare agencies, hospitals and clinics, and rehabilitation centers.

The supervisors of your students are good resource people to use as your adjunct faculty. They are aware of your clinical needs and are acquainted with your academic program, and would complement most teaching staffs.

Use of Developmental Disabilities Practitioners as Guest Lecturers

It may not always be easy to bring your class to a developmental disabilities service agency, but it may be possible to bring the experts of the field to the class. There are minorities in the developmental disabilities system who could guest lecture for one or two sessions of a course already in the curriculum. Guest lecturers should be those persons who, on a daily basis, work in the developmental disabilities system. These include: administrators, physicians, lawyers, therapists, educators, social workers, nurses and nutritionists. They bring with them a broad-based background of how the developmental disabilities system works, how they function within the system, and how your students may be able to fit into the system.

Preceptorships for Students with Minority Practitioners

The preceptorship arrangement is kin to field placement. In both situations, the student is usually assigned away from the academic arena and is to develop clinical skills at the placement site. In field placement, the student is assigned to the facility and may have the opportunity to participate in programs native to that facility with various clinical faculty.

In a preceptorship, the student is assigned to an individual who will be responsible for all or most of the exposure the student may receive. The student literally becomes the shadow of the preceptor; wherever the preceptor goes or whatever he does, so does the student. An example of this arrangement may be the social work student assigned to Mrs. Smith. Mrs. Smith's week may consist of going to family court on Monday; meeting with vocational rehabilitation on Tuesday; patient interview and counseling on Wednesday; visiting a sheltered workshop on Thursday; and going back to court on Friday. Next week's schedule may be completely different; but whatever it is, the student will be there getting valuable experience. This type of exposure offers the students many aspects of their chosen field.

Inter-Institutional Cooperation

Cooperation among historically black colleges is not a new phenomenon. There are many examples of historically black colleges joining together to share staff, students, facilities, and services. Several schools in close proximity have learned to substitute cooperation for long-standing competition. Particularly during times of diminishing economic resources, the historically black colleges should seriously consider using cooperative arrangements to plan and implement innovative programs. Often, the alternative is stagnation, resulting from the inability of a single institution to experiment with new areas of instruction.

The purpose of this section is to explore some cooperative mechanisms which could be used by the historically black colleges to develop course content and training programs in the field of Developmental Disabilities. In the course of selecting and planning an interinstitutional arrangement, the historically black colleges should follow one or more of three basic principles of collaboration.

1. Sharing. Tangibles such as faculty, students and facilities can be shared. Practicum resources and opportunities can also be shared. Sharing can include intangibles such as expertise, innovation, information and ideas.
2. Centralization. Both instructional and student services can be centralized such as recruitment, admissions, and the specialized courses and

lectures or modules. Specialized materials relating to developmental disabilities, such as books, journals, films, and videotapes, can be located in some central facility and move among cooperating institutions.

3. Division of Labor. Many collaborative arrangements are undertaken in accordance with this principle, in order to avoid wasteful competition and duplication, and to foster specialization vis-a-vis existing institutional strengths. The training programs which prepare students for full-fledged professional practice in specific disciplines are expensive. Specialization in the developmental disabilities field may add to the expense. Yet, the historically black colleges can implement these programs if smaller components are distributed to a number of collaborating institutions.

Types of Cooperative Arrangements

College Cluster. The college cluster consists of a group of colleges in close proximity that cooperate in providing educational programs and that make facilities available to students of all the colleges in the cluster. The highest degree of cooperation is achieved through this arrangement. However, it would probably be unwise for schools to enter such an arrangement merely to start a program in developmental disabilities. Yet, where clusters already exist (e.g., Atlanta University Center), they can easily be used to launch a full-scale training program in developmental disabilities, as well as for less ambitious efforts, such as curriculum enrichment in this field.

The Consortium. The consortium is a voluntary, formally organized association of higher education institutions that cooperate in offering academic programs or services, employs at least one professional administrator, and requires either annual contributions from member institutions or from outside sources as evidence of long-term commitment. Consortium arrangements are not as broad in scope as college clusters, and can be ad hoc in nature; that is, they can be set up for a specific purpose, such as to initiate a program in developmental disabilities.

A particular strength of consortia is that they can significantly increase the chances of receiving outside funding for instructional or research programs. It is possible to design a consortium to meet the needs of only two institutions. In these cases, expenses can be minimized by designating an existing faculty member to lead and coordinate the consortium program on a part-time basis. To make such an arrangement feasible, it would probably be necessary to create some type of governing board, consisting of representatives from the participating schools. This board would be responsible for making policy and financial decisions; the consortium director would execute these decisions.

The range of different variations of consortia which can be created is almost unlimited. The particular consortia can be tailored to meet the specific needs of the participating schools. In 1980, there were about 130 such bodies in the United States with about 1100 institutional members. No two of these arrangements are exactly the same. The Alabama Center for Higher Education is an example of a consortium which operates multiple academic and administrative programs.

The following cooperative arrangements are similar to consortia. In many cases, these mechanisms are not true consortia since they are not governed by a separate organizational entity supported by the member institutions.

Joint-Degree Programs. These types of arrangements are useful for highly specialized fields where the participating institutions may have complementary resources or expertise such as the existence of a professional degree program. It may be that only one historically black college in a geographic area will have a professional program in Occupational Therapy, Physical Therapy, Social Work, or Rehabilitation Nursing. If a joint-degree arrangement is put in place, students could complete their three years of liberal arts/pre-professional education at their "home" institution, and then complete their professional training at the member institution housing the professional program. Both institutions may grant degrees in areas in which the student has completed all required course work.

Partnership Arrangements. These are limited arrangements among institutions to undertake specific collaborative tasks. Some of the activities that these mechanisms can carry out are: faculty and student exchanges, curriculum enrichment, program planning, and joint student recruitment. Secondary schools and junior colleges can participate in these arrangements especially for the purpose of recruiting students into the developmental disabilities field. Partnership arrangements can evolve into more formal and complex structures; thusly, it could be wise for historically black colleges to begin their collaboration with these mechanisms while working toward full-scale, joint-degree programs or consortia.

When planning cooperative arrangements, the historically black colleges should keep in mind the following potential problems and pitfalls.

1. Autonomy. Even though a consortium may seem to take on a life of its own, it would be difficult to submerge or override the autonomy of the member institutions. The process of negotiating collaborative agreements for historically black colleges can be long and tedious; the differential distribution of roles, authority and responsibility must be worked out and made clear.

2. Communication. This is probably one of the largest problems for collaboration among historically black colleges. The usual mechanisms for arriving at consensus and for keeping members "in the know" are ad hoc committees and conferences which can drain the already overburdened faculty.

3. Self-Interest. The historically black colleges, like individuals, can have problems with what is "mine" and what is "ours." Self-interest of member institutions in a collaborative arrangement is natural and unavoidable. Planners must take into account the possible impact of vested interests, loyalties, commitments, and prestige. Cooperative efforts can begin enthusiastically, then turn sour, if these factors are not controlled.

4. Uniformity. A strength of the historically black colleges is found in their diversity. Cooperative arrangements can produce uniformity among members or accentuate differences by giving them a secure place in the new arrangement.

5. Money. Mere coordination is not expensive, but program operation is. Even though collaborative arrangements are more efficient in the long run for all of the member institutions together, they do require some initial money outlays by each member institution. The historically black colleges are reluctant to enter collaborative arrangements without sources of outside funding.

A Statewide Model - Alabama

The Alabama Center for Higher Education (ACHE), a fifteen year old, voluntary academic consortium, provided the modus operandi whereby the seven, four year HBCU's could cooperatively pursue curriculum development strategies in developmental disabilities. Recognizing that the previous workshop emphases had not included a significant emphasis on the University Affiliated Facility and that the UAF plays a key role in the developmental disabilities system, it was mutually agreed among the member institutions that establishing a linkage with the local UAF represented the next step.

Planning strategies were effectuated involving a cadre of persons representing the HBCU's; the Alabama State Department of Mental Health - Division of Mental Retardation, Office of Human Resources Development, Personnel Office; DD Planning Council; and the state's UAF, Center for Developmental and Learning Disorders at the University of Alabama in Birmingham. The cooperative planning strategies led to ACHE sponsoring a two and a half day workshop which was hosted by the UAF - CDLD for the primary purpose of reviewing and evaluating program accomplishments, and planning and developing strategies for updating curricular offerings to meet future challenges in the DD service system. The workshop's more specific objectives follow.

- To alert 50 faculty from the seven HBCU's to the needs of the developmental disabilities system;
- To prepare presentation on present status of curriculum offered at each school as relates to the DD service system (particularly Special Education, Social Work, Nursing, Psychology, Occupational Therapy, Physical Therapy, Recreation Therapy, Rehabilitation and Nutrition) and show institutional interrelatedness of departmental offerings;

- To select leading institution (an institution with a strong curriculum in a given field) to lead small clusters of faculty in the same field in discussion on methodology:

  -how to improve a given department,
  -are there accrediting bodies and give guidelines for accreditation,
  -how to piggyback on courses offered in other departments or at other HBCU's,
  -how to get assistance from outside funding agencies to build curriculum; and

- To assist faculty with designing a program or plan of action and timetables for implementation for each department represented.

Workshop Schedule. While the basic format of this workshop closely resembled that of the regional workshops, the primary difference was the latter emphasis on training and research as reflected in the role of the UAF. Additionally, the focus was on those services provided clients on an outpatient basis as compared to the regional focus on those services provided by residential facilities. And finally, the schedule was designed to provide an awareness of the interrelationships among the various components of the state's developmental disabilities system on one hand, while on the other to permit curriculum enhancement planning from both intra and interinstitutional perspectives.

Workshop Proceedings. Involved in the Awareness portion of the schedule were representatives from throughout the system who made individual presentations.

- Alabama State Department of Mental Health
  -Associate Commissioner for Mental Retardation
  -Mental Retardation Community Service Program
  -Regional Community Services
  -Personnel Office
  -Office of Human Resources Development
  -Brewer Developmental Center (residential facility)
  -Staff, DD Planning Council
  -Office of Programs for Review and Evaluation

- Center for Developmental and Learning Disorders - UAF
  - -Division of Training/Speech Pathology
  - -Division of Social Work
  - -Division of Physical and Occupational Therapy
  - -Division of Nursing
  - -Division of Psychology
  - -Division of Speech and Hearing
  - -Division of Nutrition (Birmingham Southern College)
  - -Division of Special Education (University of Alabama in Birmingham)

Participants engaged in curriculum enhancement planning by disciplines/professions and by institution. While the institutional plans reflected those same strategies previously outlined, the colleges and universities deemed it feasible to cooperatively develop linkages with the training center (UAF). Through such a linkage, faculty could be involved in training programs - both short and long term - which would serve to increase faculty awareness, lead to increased curricula emphases on DD at the respective institutions, and subsequently serve to increase minority participation in DD training which is at the graduate level.

SUMMARY

This project of national significance was designed as a first step in a move toward bridging the gap between historically black colleges and universities and the developmental disabilities system. A number of factors were taken into consideration as the project was developed. 1) Through the consortium, the HBCU's in Alabama were collaborating with the Alabama State Department of Mental Health for the primary purpose of increasing the number of minority professionals in that system via the hiring of eligible graduates from those institutions. 2) Tuskegee Institute, one of the consortium's seven members, through its Division of Allied Health which offered professional certification in Physical Therapy and Occupational Therapy, had made developmental disabilities one of its major thrusts. At the time, only one other HBCU in the country offered both programs. 3) The consortium had gained both a regional and a national visibility through other program efforts and enjoyed a close working relationship with the Southern Regional Education Board. SREB made a commitment to assist ACHE in establishing contacts at the HBCU's which was significant in that 90% of the HBCU's were in the SREB 14 state region, a region which encompassed three of the ten standard federal regions either in total or in part. 4) As a first step in bridging the gap in a national model, emphasis would be placed on introducing to and enhancing the awareness of faculty representing the disciplines and professional areas that have the knowledge and skills basic to solving problems unique to persons with developmental disabilities. 5) Faculty from HBCU's would be effective in training faculty from other HBCU's as a method of realizing the primary purpose of providing awareness.

Through the project as planned, activities were conducted in a number of sites in various parts of the country as part of a unified program. Faculty from more than 50% of the nation's HBCU's, which covered a 16 state area and three of the ten standard federal regions, participated in three regional workshops. The three workshops were hosted by large residential facilities for the developmentally disabled in Alabama, Texas and Virginia.

The mini-team concept, primarily a service tool, was borrowed and used as a training tool by a team of faculty persons from the consortium's member institutions. Assistance was provided by two University Affiliated Facilities in developing the mini-team training model, the Ohio University Affiliated Center for Human Development in Athens and the University of Alabama in Birmingham's Center for Developmental and Learning Disorders.

In addition to 15 hours of intensive preservice interdisciplinary training, faculty participants were provided training manuals to be utilized both as a training guide and resource manual for curriculum enhancement.

The curriculum enhancement strategies that were reviewed with participants included the following: change in course content/emphasis; development of new courses; interdisciplinary course teaching; field trips to developmental disabilities service sites; field placements and internships; and guest lectures. Also participants were acquainted with some interinsitutional cooperative mechanisms which could be employed by historically black colleges and universities to develop course content and training programs in the field of developmental disabilities.

It was also planned that the project would impact developmental disabilities programs throughout the country so that . . .

- State Planning Councils and related Advisory Boards on DD are made aware of a larger pool of minorities from which their memberships may be drawn.
- Programs of the University Affiliated Facilities (UAF) could be strengthened via cooperative/collaborative relationships with local HBCU's.
- An increased pool of minority applicants would be available for employment as a result of student observation and practicum experience within the DD system.
- The DD system would gain an awareness of the vast and under-utilized resources of the HBCU's in areas such as employment and staff development.

And finally, the project was to provide a replicable model which would result in an improved delivery system for developmental disabilities. A consortium arrangement, the ACHE model presents an effective strategy for institutions who desire to cooperate. Through the consortium, the seven HBCU's in Alabama are developing a statewide collaborative involving the state's University Affiliated Facility and the Mental Retardation Division of the Alabama Department of Mental Health in which DD is situated along with the Department's Personnel Office and Office of Human Resource Development.

This project, as designed, represented a first step in a move toward bridging the gap between historically black colleges and universities and the developmental disabilities system. Additional resources - fiscal and human - must be made available if the primary objective of involving HBCU's in the DD network for the purpose of increasing the number of minority professionals in the DD system is to be realized.

RECOMMENDATIONS

Having completed this project of national significance which brought together faculty from historically black colleges and universities across the country with various components of the developmental disabilities system, a number of suggestions and recommendations were set forth as presented.

Developmental Disabilities System

- That University Affiliated Facilities assume a lead role in effectuating linkages with HBCU's to assist with curriculum enhancement plans and to increase the number of minorities who train within these facilities.
- That resources of financial and technical assistance be made available to HBCU's for the development and implementation of curriculum plans in the disciplines/professions relating to developmental disabilities.
- That state DD systems increase their awareness of the HBCU's regarding programs which are offered and faculty resources which are available to aid the system in realizing its own goals and objectives.
- That increased opportunities within the DD system be made available to HBCU's for student observation and practicum experiences at the undergraduate level.
- That the federal agency responsible for DD initiatives develop, implement and support a mechanism which insures

increased participation of HBCU's in the DD network.

- That knowledgeable faculty be recruited to serve on boards and professional advisory councils of agencies and organizations serving the developmentally disabled.
- That state DD systems initiate and establish a network with HBCU's to develop and implement strategies designed to insure an available pool of eligible minority applicants for professional employment.

Historically Black Colleges and Universities

- That linkages be initiated and established with the local DD system to include:

  University Affiliated Facilities for advanced faculty training, research projects, and student observation;

  State mental health administrations;

  State developmental disabilities planning councils and other advisory bodies;

  Other private and volunteer systems.
- That an interdisciplinary approach be applied to the development and implementation of curriculum enhancement plans including the development of new courses, course teaching, change in course content/emphasis, field trips, field placements and internships, et. al.
- That networks be developed among and between HBCU's for the purposes of resource sharing and development of cooperative or dual degree programs in those professional fields serving the developmentally disabled such as occupational therapy,

physical therapy, social work, or rehabilitation nursing.

- That HBCU's assume the leadership and provide direction by becoming information centers for the assembling, ordering, and dissemination of information on developmental disabilities; i.e., become the "think tanks" for the minority developmental disabilities movement.
- That administrations within the HBCU's be sensitized to and made aware of the leadership role which the institution must assume in the DD movement relative to the education of minority professionals and involvement in the decision making area.
- That HBCU faculty be encouraged to volunteer service on boards and professional advisory boards and councils of organizations and agencies serving the developmentally disabled.
- That both college and high school career counselors be made aware of the career fields that will offer minority students opportunities in the DD system.

APPENDIX A

RESOURCES DEVELOPED BY THE PROJECT

Resources Developed By The Project

1. DD Training Manual: A Guidebook for Administrators and Faculty from HBCU's for Developing and Expanding Curricula Relative to Developmental Disabilities
2. Workshop Proceedings: Mini-Team Training on Developmental Disabilities

APPENDIX B

WORKSHOP SCHEDULES

ALABAMA CENTER FOR HIGHER EDUCATION
SPONSORS
MINI-TEAM TRAINING ON DEVELOPMENTAL DISABILITIES

MARCH 31 - APRIL 2, 1982

WORKSHOP SCHEDULE

WEDNESDAY, MARCH 31, 1982

4:00 p.m. - 7:00 p.m. ------------------ Registration - Concourse

7:00 p.m. - 8:00 p.m. ------------------ Dinner
Copenhagen/Baltic Room

8:00 p.m. - 10:00 p.m. ------------------ Session I
Copenhagen/Baltic Room

Greetings -------------------------- Charlena H. Bray

Introductions

Workshop Pre-Test

Film ------------------------------ "Davie Is Entitled"

Discussion

BREWER DEVELOPMENTAL CENTER QUALITY INN

MOBILE, ALABAMA

THURSDAY, APRIL 1, 1982

7:00 a.m. - 8:00 a.m. ----------- Continental Breakfast
Copenhagen/Baltic Room

8:15 a.m. - 8:55 a.m. ----------- Transportation provided to Brewer Developmental Center - Meet in Hotel Lobby

9:00 a.m. - 10:15 a.m. ----------- Session II

Greetings ----------------------- Ingram Gomillion
Director of Planning and Staff Development - Alabama Department of Mental Health

Cathy Arnett
Assistant Director, Brewer Developmental Center

Introduction of Keynote Speaker - Reynard McMillian
Co-Director, DD Project, ACHE

Keynote Speaker ----------------- Yetta Galiber
Executive Director, Information Center for Handicapped Individuals
Washington, D.C.

10:15 a.m. - 10:30 a.m. ----------- Coffee - Tea Break

10:30 a.m. - 12:00 noon ----------- Guided Tour of Brewer Developmental Center, Brewer Staff

12:00 noon - 1:15 p.m. ----------- Lunch, On-Site

1:30 p.m. - 4:30 p.m. ----------- Session III

Concurrent Workshops ------------ Dr. Theodore F. Childs
Chairman, Mini-Training Teams

Three concurrent workshops will be presented by the Mini-Training Team; each covers the role, function, knowledge, and skills of specified disciplines/professions as they relate to professional practice in developmental disabilities' settings, with a special focus on the following:

-the problem solving process;
-implications for curriculum development and training;
-the film, "Davie Is Entitled; and
-dialogue between the mini-team and participants.

NOTE: Please attend sessions according to the coded color of your badge; each session will last one hour.

Workshop I -------------------------- Mini-Training Team I

Naomi Hunt, Physical Therapy, Tuskegee Institute
James H. Hicks, Special Education, Alabama A&M University
Ann P. Warren, Nutrition, Alabama A&M University

Workshop II ------------------------ Mini-Training Team II

Marie L. Moore, Occupational Therapy, Tuskegee Institute
Hoyt Taylor, Recreational Therapy, Alabama State University
Melvin Davis, Psychology, Oakwood College

Workshop III ----------------------- Mini-Training Team III

Aline B. Dormer, Nursing, Oakwood College
John L. Parrish, Mobility and Sensory Training, Talladega College
Francis Taylor, Social Work, Tuskegee Institute

4:30 p.m. - 5:00 p.m. ---------------- Transportation provided to Quality Inn

6:00 p.m. - 7:15 p.m. ---------------- Dinner
Copenhagen/Baltic Room

7:30 p.m. - 9:00 p.m. ---------------- Session IV
Copenhagen/Baltic Room

Francis Taylor, Tuskegee Institute - Moderator
Working groups led by mini-team members will focus on the development of intra- and inter-institutional plans.

NOTE: The film "Davie Is Entitled," will be shown for those who have not seen it.

FRIDAY, APRIL 2, 1982

7:00 a.m. - 8:00 a.m. ---------------- Continental Breakfast
Copenhagen/Baltic Room

8:15 a.m. - 8:55 a.m. ---------------- Transportation provided to Brewer Developmental Center - Meet in Hotel Lobby

9:00 a.m. - 11:00 a.m. ---------------- Session V

Francis Taylor, Tuskegee Institute - Moderator
Development of Intra- and Inter-institutional plans
Individual Group Reports on Plans
General Group Share-Out

11:00 a.m. - 11:15 a.m. ---------------- Coffee-Tea Break

11:15 a.m. - 12:00 noon ---------------- Closing Session

Workshop Post-Test
Conference Evaluation ------------ William D. Lawson
Project Evaluator,
Alabama State University

Announcements

Reimbursement Information

Adjournment

ALABAMA CENTER FOR HIGHER EDUCATION

sponsors

MINI-TEAM TRAINING ON DEVELOPMENTAL DISABILITIES

April 14 - 16, 1982

Austin State School
Villa Capri Motor Hotel
Austin, Texas

WORKSHOP SCHEDULE

Wednesday, April 14, 1982

4:00 p.m. - 7:00 p.m.		Registration - Hotel Lobby
7:00 p.m. - 8:00 p.m.		Dinner - Buffet, Green Room
8:15 p.m. - 10:00 p.m.		Session I - Entertainment Center
	Greetings	Charlena H. Bray, Executive Director Alabama Center for Higher Education
	Introductions	
	Workshop Pre-Test	William D. Lawson Project Evaluator, Alabama State University
	Film	"Davie Is Entitled"
	Discussion	

Thursday, April 15, 1982

7:00 a.m. - 8:00 a.m.		Breakfast - Hotel Dining Room
8:15 a.m. - 8:55 a.m.		Transportation provided to Austin State School - Meet in Hotel Lobby
9:00 a.m. - 10:15 a.m.		Session II
	Greetings	The Honorable Wilhelmina Delco State Representative
		B.R. Walker, Superintendent Austin State School
		Volma Overton, President Austin NAACP

Thursday, April 15, 1982

9:00 a.m. - 10:15 a.m.

Introduction of Keynote Speaker . . . . . Reynard McMillian, Co-Director
DD Project, ACHE

Keynote Speaker . . . . . Raymond F. Holmes
Assistant Commissioner for Mental Retardation, Department of Mental Health and Mental Retardation, Richmond, Virginia

10:15 a.m. - 10:30 a.m. Coffee-Tea Break

10:30 a.m. - 11:45 a.m. Guided Tour of Austin State School
Gwyn Boyter, Director of Staff Services

12:00 noon - 1:45 p.m. Lunch - On-site

1:30 p.m. - 4:30 p.m. Session III

Concurrent Workshops . . . Theodore F. Childs, Chairman
Mini-Training Teams

Three concurrent workshops will be presented by the Mini-Training Team; each covers the role, function, knowledge, and skills of specified disciplines/professions as they relate to professional practice in developmental disabilities' settings, with a special focus on the following:

- the problem solving process;
- implications for curriculum development and training;
- the film, "Davie Is Entitled", and
- dialogue between the mini-team and participants.

Note: Please attend sessions according to the coded color of your badge; each session will last one hour.

Workshop I . . . . Mini-Training Team I

Naomi Hunt, Physical Therapy, Tuskegee Institute
James H. Hicks, Special Education, Alabama A&M University
Ann P. Warren, Nutrition, Alabama A&M University

Thursday, April 15, 1982

1:30 p.m. - 4:30 p.m.

Concurrent Workshops . . . Theodore F. Childs, Chairman
Mini-Training Teams

Workshop II . . . . Mini-Training Team II

Marie L. Moore, Occupational Therapy, Tuskegee Institute
Hoyt Taylor, Recreational Therapy, Alabama State University
Melvin Davis, Psychology, Oakwood College

Workshop III . . . . Mini-Training Team III

Aline B. Dormer, Nursing, Oakwood College
John L. Parrish, Mobility and Sensory Training, Talladega College
Francis Taylor, Social Work, Tuskegee Institute

4:30 p.m. - 5:00 p.m.	Transportation provided to Villa Capri Motor Hotel
7:00 p.m. - 8:00 p.m.	Dinner - Buffet, Green Room
8:00 p.m. - 10:00 p.m.	Session IV Francis Taylor, Tuskegee Institute Moderator

Working groups led by Mini-Team members focusing on the development of intra and inter-institutional plans.

Note: The film, "Davie Is Entitled," will be shown for those who have not seen it.

Friday, April 16, 1982

7:00 a.m. - 8:00 a.m.	Breakfast - Hotel Dining Room
8:15 a.m. - 8:55 a.m.	Transportation provided to Austin State School - Meet in Hotel Lobby
9:00 a.m. - 11:00 a.m.	Session V Francis Taylor, Tuskegee Institute Moderator

- Development of Intra and Inter-institutional plans
- Individual group reports on plans
- General Group Share-Out

Friday, April 16, 1982

11:00 a.m. - 11:15 a.m. Coffee-Tea Break

11:15 a.m. - 12:00 noon Closing Session

Workshop Post-Test

Conference Evaluation . . . . William D. Lawson
Project Evaluator, Alabama State University

Announcements

Reimbursement Information

Adjournment

ALABAMA CENTER FOR HIGHER EDUCATION

sponsors

MINI-TEAM TRAINING ON DEVELOPMENTAL DISABILITIES

April 21 - 23, 1982

WORKSHOP SCHEDULE

Wednesday, April 21, 1982

4:00 p.m. - 7:00 p.m. . . . . Registration - Madison Room

7:00 p.m. - 8:00 p.m. . . . . Dinner - Buffet, Madison/Jefferson Room

8:15 p.m. - 10:00 p.m. . . . . Session I - Madison/Jefferson Room

Greetings . . . . Charlena H. Bray, Executive Director
Alabama Center for Higher Education

Introductions

Workshop Pre-Test . . . . William D. Lawson
Project, Evaluator
Alabama State University

Film . . . . "Davie Is Entitled"

Discussion

Thursday, April 22, 1982

7:00 a.m. - 8:00 a.m. . . . . Breakfast - Madison/Jefferson Room

8:15 a.m. - 8:55 a.m. . . . . Transportation provided to Southside Virginia Training Center - Meet in Hotel Lobby

SOUTHSIDE VIRGINIA TRAINING CENTER RAMADA INN

PETERSBURG, VIRGINIA

Thursday, April 22, 1982

9:00 a.m. - 10:15 a.m.

Greetings . . . . Raymond F. Holmes
Assistant Commissioner for Mental Retardation, Department of Mental Health and Mental Retardation

Richard Beckley, Superintendent
Southside Virginia Training Center

Introduction of Keynote Speaker . . . . . Reynard McMillian, Co-Director
DD Project, ACHE

Keynote Speaker . . . . . Walter Barwick, Deputy Director
White House Initiative on Black Colleges and Universities, U.S. Department of Education, Washington, D.C.

10:15 a.m. - 10:30 a.m. . . . . Coffee-Tea Break

10:30 a.m. - 11:45 a.m. . . . . Guided Tour of Southside Virginia Training Center

12:00 noon - 1:15 p.m. . . . . Lunch - On-Site

1:30 p.m. - 4:30 p.m. . . . . Session III

Concurrent Workshops . . . Theodore F. Childs, Chairman
Mini-Training Teams

Three concurrent workshops will be presented by the Mini-Training Teams; each covers the role, function, knowledge, and skills of specified disciplines/professions as they relate to professional practice in developmental disabilities' settings, with a special focus on the following:

- -the problem solving process;
- -implications for curriculum development and training;
- -the film - "Davie Is Entitled", and
- -dialogue between the mini-team and participants

NOTE: Please attend sessions according to the coded color of your badge; each session will last one hour.

Thursday, April 22, 1982

1:30 p.m. - 4:30 p.m. . . . . Concurrent Workshops

Workshop I . . . . Mini-Training Team I

Naomi Hunt, Physical Therapy, Tuskegee Institute
James H. Hicks, Special Education, Alabama A&M University
Ethel Saunders, Nutrition, Alabama A&M University

Workshop II. . . . . Mini-Training Team II

Marie L. Moore, Occupational Therapy, Tuskegee Institute
Hoyt Taylor, Recreational Therapy, Alabama State University
Melvin Davis, Psychology, Oakwood College

Workshop III . . . . Mini-Training Team III

Aline B. Dormer, Nursing, Oakwood College
John L. Parrish, Mobility and Sensory Training, Talladega College
Francis Taylor, Social Work, Tuskegee Institute

4:30 p.m. - 5:00 p.m. . . . . Transportation provided to
Ramada Inn

7:00 p.m. - 8:00 p.m. . . . . Dinner - Madison/Jefferson Room

8:15 p.m. - 10:00 p.m. . . . . Session IV

Francis Taylor, Tuskegee Institute
Moderator

Working groups led by Mini-Team members focusing on the development of intra and inter-institutional plans.

Friday, April 23, 1982

7:00 a.m. - 8:00 a.m. . . . . Breakfast - Madison/Jefferson
Room

8:15 a.m. - 8:55 a.m. . . . . Transportation provided to
Southside Virginia Training Center -
Meet in Hotel Lobby

9:00 a.m. - 11:00 a.m. . . . . Session V

Francis Taylor, Tuskegee Institute
Moderator

- Development of Intra and Inter-institutional plans
- Individual Group Reports on Plans
- General Group Share-Out

Friday, April 23, 1982

11:00 a.m. - 11:15 a.m. . . . . Coffee-Tea Break

11:15 a.m. - 12:00 noon . . . . Closing Session

Workshop Post-Test

Conference
Evaluation . . . . William D. Lawson
Project Evaluator, Alabama
State University

Announcements

Reimbursement Information

Adjournment

ALABAMA DEVELOPMENTAL DISABILITIES WORKSHOP

OCTOBER 27-29, 1982

AGENDA

3:30 – 5:00 p.m.	REGISTRATION	
5:30 – 6:30 p.m.	DINNER	
6:30 – 7:30 p.m.	WELCOME & INTRODUCTION OF TEAM	Mrs. Charlena H. Bray Executive Director, ACHE
	INTRODUCTION OF KEYNOTE SPEAKER	Mrs. Ella Bell, Human Resource Specialist, DMH
	KEYNOTE ADDRESS	Mr. Jerry Thrasher Associate Commissioner for Mental Retardation and Superintendent of Facilities, DMH
	WORKSHOP OBJECTIVES AND FORMAT	Dr. Theodore F. Childs Chairman, ACHE Mini Team Assistant Professor, HPER Alabama State University
8:00 – 10:00 p.m.	ICE BREAKER	Suite 1114 Holiday Inn-Medical Center

SESSION I — WEDNESDAY OCTOBER 27 — HOLIDAY INN — MEDICAL CENTER

AGENDA

9:00 – 10:30 a.m. PANEL DISCUSSION

Staff, Alabama State
Department of Mental Health

- Mr. Ray Owens
  Director of Mental
  Retardation Community
  Service Program
- Mr. Dale Scott
  Staff Director,
  DDP Council
- Dr. Paul Johnson
  Chief, Programs for
  Review and Evaluation
- Ms. Catherine Arnette
  Assistant Director
  Brewer Developmental Center
- Ms. Kathy Elmore
  Coordinator, Region I
  Community Services
- Mr. Henry Ervin
  Director
  Personnel

10:30 – 10:45 a.m. BREAK

10:45 – 12:Noon SLIDE PRESENTATION

TOUR OF CENTER FOR DEVELOPMENTAL LEARNING DISORDERS (CDLD)

12:00 – 1:30 p.m. LUNCH

1:30 – 3:30 p.m. INTERDISCIPLINARY PANEL DISCUSSION

CDLD Staff

- Dr. Ronald Goldman
  Division of Training/
  Speech Pathology
- Dr. Dale Brantley
  Director
  Division of Social Work
- Dr. Joan Bergman
  Director, Physical &
  Occupational Therapy
- Ms. Betty Bell
  Director of Nursing
  CDLD
- Dr. Arnold Mindingall
  Interim Director
  Division of Psychology
- Dr. Arthur Dahle
  Director
  Speech and Hearing
- Dr. Harriet Cloud
  Director of Nutrition
  Birmingham Southern College
- Dr. Elizabeth McIntire
  Assistant Professor,
  Department of Special Education, UAB

3:30 – 4:30 p.m. OBSERVATION OF INTERDISCIPLINARY PROCESS IN ACTION .... CDLD

4:30 – 5:30 p.m. BREAK

SESSION VI — THURSDAY OCTOBER 28 — HOLIDAY INN — MEDICAL CENTER

AGENDA

ATLANTA ROOM

5:30 – 6:30 p.m. DINNER

Atlanta Room
Holiday Inn-Medical Center

6:30 – 8:00 p.m. BREAKOUT BY DISCIPLINES
(for curricula development and strategy sessions)

Facilitators:

Dr. Francis Taylor
Dr. William Lawson
Dr. Melvin Davis

Group I (Special Education)

Dr. James Hicks — Alabama A&M University
Ms. Catherine Arnette — Brewer Developmental Center
Dr. John Parrish — Talladega College

Group II (Social Work & Psychology)

Dr. Francis Taylor — Tuskegee Institute
Ms. Kathy Elmore — Wallace Developmental Center
Dr. Melvin Davis — Oakwood College
Dr. Arnold Mindingall — CDLD
Dr. William Lawson — Alabama State University

Group III (Nursing, Dietetics/Nutrition, Allied Health, Recreation, Occupational and Physical Therapy)

Mrs. Aline Dormer — Oakwood College
Ms. Marie Moore — Tuskegee Institute
Dr. Theodore F. Childs — Alabama State University
Dr. Joan Burgman — CDLD
Ms. Betty Bell — CDLD
Dr. Hoyt Taylor — Alabama State University
Mrs. Ann Warren — Alabama A&M University

8:00 – 9:30 p.m. BREAKOUT BY INSTITUTIONS FOR IDENTIFICATION OF RESOURCE PERSONS AND DECISION ON AREAS OF CONCENTRATION FOR DEVELOPMENT OF INSTITUTIONAL PLAN

Birmingham Room
Holiday Inn-Medical Center

A G E N D A

BIRMINGHAM ROOM

9:00 – 10:30 a.m.	FINALIZE INSTITUTIONAL PLANS UTILIZING INDIVIDUAL CURRICULA RESOURCE PERSONS Facilitators: Dr. Francis Taylor Tuskegee Institute Dr. William Lawson Alabama State University Dr. Melvin Davis Oakwood College
10:30 – 12:Noon	PRESENTATION OF INSTITUTIONAL PLANS & STRATEGIES FOR INTERINSTITUTIONAL COOPERATION FOR CURRICULA DEVELOPMENT
12:Noon	ADJOURNMENT

– ACKNOWLEDGMENT –

This workshop was coordinated by the Human Resources Research and Development Program of the Alabama Center for Higher Education. Staff members include:

Reynard R. McMillian, Project Director
Colette L. Monroe, Administrative Assistant
Phyllis D. Hollings, Administrative Assistant/Secretary

APPENDIX C

WORKSHOP PARTICIPANTS

MINI-TEAM TRAINING ON DEVELOPMENTAL DISABILITIES

ALABAMA, TEXAS, AND VIRGINIA

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MINI-TEAM TRAINING ON DEVELOPMENTAL DISABILITIES

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APPENDIX D

PARTICIPANT EVALUATION FORM

ALABAMA CENTER FOR HIGHER EDUCATION

DEVELOPMENTAL DISABILITIES WORKSHOP

____ PARTICIPANT EVALUATION FORM ____

We need your honest and critical evaluation of this workshop in order to successfully determine its effectiveness, and to have advantage of your input concerning ways and means of improving future workshops.

To evaluate this workshop, please check (✓) the space provided for each breakout session you attended (including pre-registration package, keynote address and film) using the following rating scale of 1-10, with 10 being the highest. Place the number you selected from the rating scale that best describes the degree of beneficial knowledge, information, etc., you received in the rating space opposite each session you attended. Support each rating with a concise comment(s) in the space provided under each rating.

SCALE: Low 1 2 3 4 5 6 7 8 9 10 High

1. Pre-registration package: Rating ______
   Comment(s)

2. Keynote Speaker: Rating ______
   Comment(s)

3. Film: Rating ______
   Comment(s)

4. Breakout Sessions

   Team 1: Rating ______
   Comment(s)

   Team 2: Rating ______
   Comment(s)

   Team 3: Rating ______
   Comment(s)

Participant Evaluation Form
Page Two

5. Did this workshop provide you any new ideas or broaden your understanding of the Developmental Disabilities Service Delivery System?

   Yes ______

   No ______

6. Do you feel your institution will implement a personnel preparation program in one of the areas serving the developmentally disabled?

   Yes ______

   No ______ If not, why not?

7. If you have any suggestions that you believe would aid in the improvement of future workshops in order to make them more meaningful, please list:

ADDITIONAL REMARKS:

APPENDIX E

CURRICULUM DEVELOPMENT PLANNING FORM

CURRICULUM DEVELOPMENT PLANNING FORM

DIVISION/DEPARTMENT/OFFICE ____________________ COLLEGE/SCHOOL/AREA ____________________

SUBMITTED BY: ____________________ DATE: ____________________

GOALS	ACTIVITIES TO ACHIEVE OBJECTIVES	INITIATION AND COMPLETION DATES

CURRICULUM DEVELOPMENT PLANNING FORM

DIVISION/DEPARTMENT/OFFICE ______________________ COLLEGE/SCHOOL/AREA ______________

SUBMITTED BY: ______________________ DATE ______________

GOAL(S)	STATEMENT OF END OF YEAR GOAL STATUS	RESULTS MEASUREMENT

ALABAMA CENTER FOR HIGHER EDUCATION
INSTITUTIONAL PROGRESS REPORT CHECKLIST

	YES	NO
1. Have individual workshop participants used materials from workshop in your classrooms?	____	____
2. Have you shared materials with colleagues?	____	____
3. Have you added or reorganized a unit on Developmental Disabilities in your classroom?	____	____
4. Has a new course been developed in your discipline?	____	____
5. Has an interdisciplinary course been added to your curriculum?	____	____
6. Has a minor been added in Developmental Disabilities?	____	____
7. Has a major been added in Developmental Disabilities?	____	____

*NOTE: If you have not completed any of the items 3 thru 7 check appropriately.

1. Lack of financial support ______
2. Lack of divisional approval ______
3. Lack of professional personnel ______
4. Other ______________________________

	YES	NO
8. Considering the above in your opinion will your institution be able to implement any or all of items 3 thru 7?	____	____

Department ____________________________ Division ____________________________

Institution ____________________________ Faculty Person ______________________

S.S.N. ____________________________

Please return this portion with hbcu's progress report.

Please indicate whether a national coalition of faculty hbcu's should be established to advance the cause of increasing the number and quality of minority professionals in Developmental Disabilities.

____ YES ____ NO